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ABSTRACT

This periodical issue focuses on infants and toddlers and the justice system. The main article is entitled: "Families, Infants and the Justice System," written by Robert Horowitz. It looks at the role of the justice system in family dissolution and creation, the use of courts to resolve disputes, the role of the justice system in family dysfunction, benefit programs and challenging their decisions, personal injury suits (torts), and the relationship of the infant/family professional to the justice system. A second article is "Bearing Witness for Babies: The Role of the Expert Witness" (Kyle D. Pruett). This article examines transformation of a clinician into a forensic agent, key characteristics of the expert infant clinician as a witness, the forensic investigation and report, and the testimony itself. A third article is "Kinship Care: Developing a Safe and Effective Framework for Protective Placement of Children with Relatives" by Marianne Takas. It discusses development of an appropriate legal, fiscal, and service framework for kinship care cases when a relative is selected as an appropriate placement resource. Next, "Babies in Prison", by Jean Harris, considers the prison nursery system today, Rene Spitz' insights concerning the best interests of the child, a parenting class, life in the prison nursery, changing patterns of care, and funding for prison nurseries. Other articles are: "A Toddler Experiences Joint Custody: Journal Observations" (Suzi Tortora); "Infants, Toddlers, and SSI: Changing the Rules, Reaching the Children" (Rhoda Schulzinger); "Head Start: The Next Generation" (Edward Zigler and Susan Muenchow). Other features include book notes, program notes, and a list of conferences. (DB)

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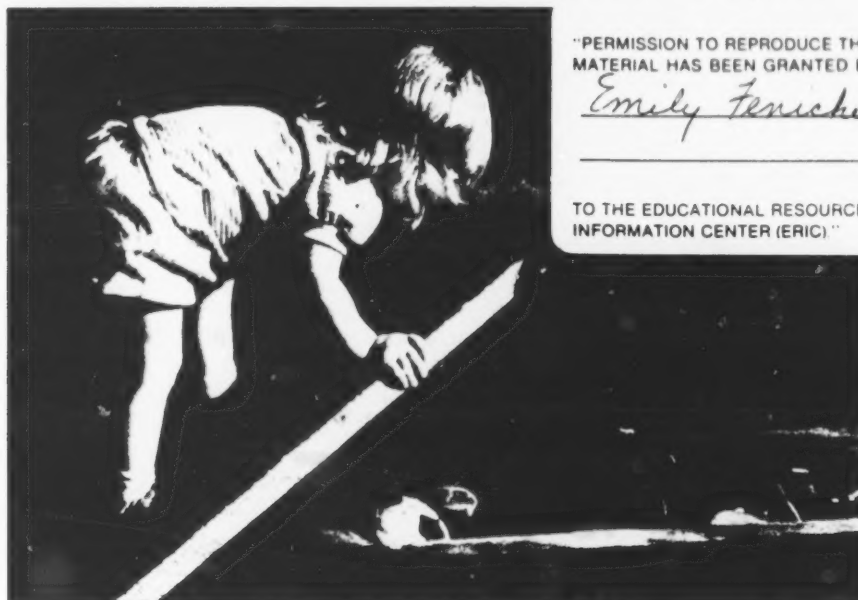
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Families, Infants and the Justice System



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BARBARA YOUNG

Robert Horowitz, J.D., *Center on Children and the Law; American Bar Association, Washington, D.C.*

Most disputes between individuals or between individuals and institutions are settled informally, whether or not a child is involved. Neighbors reach compromises, insurance companies settle claims, fathers admit paternity, and parents volunteer to cooperate with child protection agencies. Only when differences become intractable is the "justice system" evoked.

Unfortunately, this system can confuse the most astute individuals. Justice "forums" range from informal neighborhood dispute centers (where volunteer mediators offer to resolve a range of disputes) to federal courts. The issues cover criminal and civil matters. The actors include state agencies, government officials, prosecutors, and individuals (including parents and children). The procedural rules may be strict and formalistic, loose and open-ended, or something in between.

Where, who, and how we resolve disputes depends largely on the "why." When infants and toddlers are involved, the why generally centers on one of four situations: family

dissolution and creation, family dysfunction, denial of a public benefit, or a personal injury. In all of these situations, infants, toddlers, and their families are likely to be best served when they have access to informal, volunteer, and professional helpers who are knowledgeable about the justice system. This article presents an overview of the system as it is most likely to be experienced by very young children and their families, and suggests resources for further study and consultation.

Family dissolution and creation

Why is the justice system involved? The definition of family seems clearest at childbirth: mother, father, and baby. When the parents aren't married, however, the legal relationships are not always as certain. Thus the earliest legal question can involve the most fundamental of all concerns: parentage, and in particular, fatherhood. Thanks to modern technology, this determination is mostly scientifically determined through sophisticated blood tests or DNA matching. But also thanks to technology, the legal

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definition of "mother" is no longer absolute. Alternative reproductive technologies, such as surrogacy and in vitro fertilization, have opened the door to new interpretations and battles about who may be a baby's legally recognized mother. The justice system itself can create legal family relationships, through the process of adoption.

When a "traditional" family—married couple with child—dissolves, legal relationships may need redefining. With each failed marriage, issues of child custody, visitation, and support must be resolved.

Where and how are disputes resolved? Family creation/dissolution cases are heard in state courts. Under a rule in American jurisprudence called the "domestic relations exception," federal courts are reluctant to decide cases which may alter or affect family relationships.

State courts are created by state legislatures. Which specific state court has "jurisdiction" over matters of family creation and dissolution will vary by state and even county. Some states, such as Delaware, Hawaii and Rhode Island, have created unified family courts. These courts exist throughout the state and hear all cases involving family matters, ranging from paternity to patricide. (For further information on family court structure, see, S. Katz and J. Kuhn, "Recommendations for a Model Family Court: A Report from the National Family Court Symposium," National Council of Juvenile and Family Courts, Reno, NV 1991 and L. Edwards, "The Juvenile Court and the Role of the Juvenile Court Judge," *Journal of Juvenile and Family Court*, Vol. 43, No. 2 1992) In other states, family courts may exist in larger counties and have jurisdiction over many, but not usually all matters affecting children and families. In most communities, family dissolution matters are heard by trial courts that handle a variety of legal matters.

Which type of court hears these cases can be significant. The expertise required to resolve disputes related to the creation or dissolution of a family often exceeds traditional legal knowledge. Issues of child development, family dynamics, and economic and emotional consequences of divorce all play a role. If a court specializes in these cases, there is a greater chance that its decision will be based on appropriate specialized judicial expertise and knowledge. In addition, the more specialized the court, the more likely it is that auxiliary services exist to aid in judicial fact finding. These may include diagnostic, counseling and alternative dispute resolution services (ADR).

ADR services, especially mediation, offer a non-judicial forum for resolving disputes about the family within the family. In mediation, a neutral third party assists and facilitates the resolution of disputes between the parents. In the last decade mediation has gained increased popularity in child custody cases, given its convenience, speed, and affordability, as well as its respect for family privacy and self-determination.

In some states, such as California, Florida and Texas, the courts may require litigants to attempt mediation before bringing a dispute to court. In most states, mediation is merely an option, often encouraged by the judge and provided by private mediators. Mediation has proven

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successful in custody and visitation disputes, provided an imbalance of power does not exist between the parents. Where one parent predominates the relationship, or there is a history of domestic violence, mediation is not recommended.

The mediation process is less formal and rule-driven than judicial procedures. The mediation process centers on problem identification, the generation and evaluation of alternative solutions, selection of a solution, and agreement by the parties. The mediator herself can not dictate the agreement or order the parties to do anything. Mediation styles and formats, and even the professional background of the mediator, vary greatly. Often mediators will meet separately with each party, and then as a group, in order to understand everyone's interest and help develop options to settle the dispute.

Where the care and well-being of a child is at stake, even mediated agreements must be approved by the court. Where post-judgment disputes arise, the parties may return to the mediation process, rather than seeking contempt proceedings.

Who are the litigants? Although family creation and dissolution disputes involve issues of fundamental importance to infants and toddlers, babies are mostly bystanders to the legal proceedings, which are structured as disputes between parents. In the case of paternity establishment, the state may also be an actor (as a precondition to establishing and enforcing child support obligations). In limited circumstances, extended family members, such as grandparents seeking visitation rights, may participate. Unlike school age children and adolescents, whose views and concerns may be directly ascertained by the judge or mediator (in many states, the older child's preference in custody matters must be considered), infants and toddlers cannot state their opinions verbally. However, many states permit or require the appointment of a lawyer in custody disputes to represent the child's best interests.

Family dysfunction

Why is the justice system involved? When family disarray—whatever its causes—results in danger to a child, the state may take protective action. The state's authority derives from the legal concept of *parens patriae*, or parent of the country. Under this common law concept, today codified in state child abuse and neglect laws, the state has an obligation to protect the health and welfare of persons, such as minors, unable to protect themselves.

When the state executive branch, through a child welfare or law enforcement agency, intervenes into the family, the justice system—that is, the courts—becomes the guardian of the parents' and child's legal rights. Thus before a child is removed from home and parents, the state must prove in court that the child is actually endangered and that the state has made "reasonable efforts" to rehabilitate the family before placing the child out of the home. In the most extreme form of intervention—an action to terminate parental rights—the state must demonstrate that

Editor's note:

This issue of *Zero to Three* is about infants, toddlers, families and the justice system. For some of us who work with young children and families, contact with courts, administrative hearings, or protective services is part of our daily professional experience. Others of us see the impact of the justice system on infants, toddlers, and families at one remove—through the eyes of young children and parents coping with divorce, for example, or accounts of the efforts of families and service coordinators to establish children's eligibility for benefits. Whatever our personal or professional connection to the justice system may be, we need to acknowledge it as a powerful force in the ecology of early childhood.

Fortunately, the contributors to this issue are experienced guides to the justice system. **Robert Horowitz** provides an overview of the justice system as it resolves disputes connected to family dissolution and creation, family dysfunction, denial of public benefits, and personal injuries. **Marianne Takas** addresses the appropriate legal, fiscal, and service framework for "kinship care," the official placement of children with relatives as a form of foster care. **Rhoda Schulzinger** outlines major changes in Social Security's procedures for determining children's eligibility for Supplemental Security Income (changes resulting both from court decisions and regulatory review); she describes ways in which infant/family practitioners can inform and assist potentially eligible families.

Suzi Tortora provides in-the-moment observations of a toddler's first experiences of joint custody and reflects on her own efforts to support the child's mother—as friend, informational resource, and trained observer of young children's emotional development. **Kyle Pruett** tells infant/family practitioners what to expect if they take on the challenging role of expert witness in the legal system. Writing from Bedford Hills Correctional Facility, **Jean Harris** describes the lives of mothers and infants in prison. (New York State is unique in allowing selected women prisoners to keep their babies with them for the first year of life.)

We are privileged to include in this issue excerpts from **Edward Zigler** and **Susan Muenchow's** *Head Start: The Inside Story of America's Most Successful Educational Experiment*, just published by Basic Books. Zigler and Muenchow offer detailed recommendations for the expansion of Head Start's services to infants, toddlers, and their families.

termination is in the child's best interest and that the statutory permitted grounds for termination have been met.

Where and how are disputes resolved? Family dysfunction cases might be heard in a civil or in a criminal

court. The choice of forum rests with the state prosecuting authorities. As in dissolution/creation cases, the civil court might be a unified family court, family court, or court of general jurisdiction.

Most abuse/neglect cases are heard in civil court. However, criminal charges, especially those involving sexual abuse or serious physical abuse, may be filed in criminal courts (usually state courts, but sometimes federal or tribal courts if the abuse occurred on federal property such as a military installation or a reservation).

Civil and criminal courts differ in important ways, including the required degree of proof, the dispositional options, and the constitutional safeguards. In civil maltreatment cases, most states require that the state prove its case by a preponderance of evidence (i.e., a greater than equal chance). In criminal cases, the state has to achieve proof "beyond a reasonable doubt." In civil cases, disposition focuses on treatment and what can be done to remedy the problems causing family dysfunction. In criminal cases, punishment is the focus (although treatment of the offender may be incorporated). In civil cases, the proceedings may be closed to the public, and indigent parents might not be represented by counsel. In criminal cases, the proceedings are open, and indigent parents are afforded counsel.

In some communities, a single family may be involved in a civil maltreatment case, a criminal maltreatment case, and a family dissolution proceeding, all taking place simultaneously in three different courts. When this occurs, problems of communication between courts may result in court orders that work at cross purposes. For example, a civil court might order that services be provided to help keep a dysfunctional family intact; a criminal court, as a condition of probation, may order the offending parent to keep away from the family.

Who are the litigants? Whereas individuals bring their own family dissolution cases to a mediator or a court, the state itself brings "dysfunction" cases, civil or criminal, against parents. Due to the imbalance of power between the parties, alternative dispute resolution methods are rarely used, although some communities are beginning to experiment in this area.

Families with infants and toddlers are disproportionately represented in dysfunction cases. State child welfare agencies consider infants and toddlers to be at greater risk of parental maltreatment, due to their peculiar vulnerability to and dependency on their caretaker. This is especially true of young children with disabilities or serious medical problems; their needs for special care can contribute to parental stress.

Poor families and racial and ethnic minorities are also overrepresented among these cases. Explanations for this phenomenon vary; some observers note the extraordinary stresses that poverty places on families; others point to cultural insensitivity within the child welfare system.

In some dysfunction cases, a third party (in addition to the state agency and the parents) may be involved in litigation. For example, a hospital, citing medical neglect,

may petition a court to perform life-saving surgery on a child when the parent has refused to consent to the operation, or a foster parent may bring an action seeking to terminate parental rights on behalf of the foster child.

As in dissolution cases, the child is not a formal party to the case. However, in dysfunction cases there is no presumption that the parties—the state and parent(s)—represent the child's best interests. Most states provide for the appointment of an attorney or lay guardian *ad litem* in civil cases to represent the best interests of the child. In many communities, lay persons volunteer as Court Appointed Special Advocates (CASAs) to provide this representation. In criminal abuse cases, the child may be assisted by a victim advocate, who attends to the child's emotional needs as they arise during litigation.

Benefit programs

Federal and state governments have created a variety of programs to assist children and families. These programs provide cash subsidies, nutrition assistance, social services, education and training, health care, and housing assistance. The recipient may be a parent or caretaker, third party, or child, or it may be an agency or program which uses government funds to provide direct services to families.

Many government-funded programs are especially geared towards infants and/or preschool children. These often focus on the child's early physical, educational, and emotional development. Examples include early childhood intervention programs, the supplemental food program for women, infants and children (WIC), Head Start, and Maternal and Child Health block grants. Other programs are designed to assist low income families with children of any age; these include Aid to Families with Dependent Children, Food Stamps, Supplemental Security Income (SSI), school lunch programs, foster care, adoption assistance, and low income housing assistance.

The eligibility criteria for benefit programs can be complex. To receive benefits, an individual or family may have to pass a **means** test, related to the family's income and assets, or a **condition** test, involving documentation of age or mental/developmental/physical condition. Eligible individuals have a personal stake in these benefits, and a right (in some instances constitutionally recognized) to challenge administrative decisions which deny, terminate, reduce, suspend, or alter the form of the benefit.

Where can agency decisions be challenged? Challenges to an adverse decision are typically brought before the agency that administers the benefit program. Common terms for these challenges are **grievance procedures**, **due process hearings**, and **fair hearings**.

The federal statute which creates a benefit often sets forth minimal administrative review requirements, but leaves states free to fashion the hearing format. Often, this is a tiered process. For example, in many WIC, AFDC, and special education programs, the first review occurs before the local administering agency, with a right to appeal to a state-level fair hearing.

Administrative dispute-resolution procedures are usually less formal than judicial proceedings. They are presided over by an "impartial" administrative law officer or judge. The rules of evidence tend to be more relaxed, but litigants are entitled to basic due process protection, usually including the right to notice, to be present, to present evidence, to confront and challenge adverse witnesses, to review agency records, and to be represented by counsel.

Additionally, federal law may provide for appeals of adverse administrative rulings, often to a state or federal district court, as is the case in special education matters. Federal district courts are created by Congress. Their judges are appointed for life by the President and confirmed by the Senate. Since the district court is the general trial court for the federal justice system, judges hear all types of cases and may have no specialized knowledge of benefit programs.

Since administrative hearings may be expensive and time consuming, increased attention has been placed on mediating disputes. Approximately half of the states, for example, have inserted a mediation step prior to due process hearings regarding disputes over a child's Individual Educational Plan.

Who are the litigants? Actions alleging inappropriate denial or change of a benefit involve the benefit applicant/recipient and the agency which administers the benefit, such as a local school board or county welfare department.

Personal Injury Suits (Torts)

Torts are civil actions brought by individuals to redress a wrong or harm committed against them. They include, for example, claims of negligence, invasion of privacy, assault and battery, and defamation. In bringing these actions, the plaintiffs are seeking monetary damages. Infants and toddlers may be plaintiffs in these cases.

Definitions of what actions constitute a tort are found in common law (early English law), state statutes, and court decisions. The evolution of tort law as a result of interplay among these sources is relevant to the way we conceptualize harm that befalls infants and toddlers.

"Wrongful life" is an example of a potential tort. Some legal theorists argue that a child born with an inherited disease or impairment could sue a third party, such as a physician or genetic counselor, for failing to properly diagnose or advise his patients (the child's parents) of the risks of such conditions. Had the parents been properly advised, this theory holds, they might have elected to prevent conception or abort the pregnancy, thereby sparing the child pain and suffering. To date, this cause of action has not been recognized in common law or state statutes. State courts have also declined to recognize such actions, citing as public policy the belief that it is better to be born, even with a disease or disability, than never to have lived. On the other hand, many courts have recognized "wrongful birth" claims, which are suits brought by parents who seek compensation, under the same circumstances, for extraordinary medical and other expenses that arise from caring for a child with serious illness or disabilities.

Another new tort theory, not recognized in common law or early American jurisprudence, involves suits by children against their parents. Until recent times, most courts adhered to the parental immunity doctrine, which held that children could not legally bring tort suits against their parents. The underlying rationale was that such suits would upset family harmony, deplete family resources, and occasion collusion among family members. Courts in most states have now have rejected the parental immunity doctrine, however, and children may sue their parents under a variety of circumstances.

A third new tort theory, which combines aspects of the two discussed above, involves prenatal injuries to children which are attributed to a parent. According to this prenatal tort theory a child could sue its mother for conduct or behavior while pregnant (e.g., drinking alcohol) which contributed to birth defects and/or developmental problems in the child. Again, no common law precedent or statutory authority exists for such a suit, and courts have been slow to recognize these actions. (Even if children could bring such suits, it is quite difficult to prove that a particular parental behavior did in fact have a teratogenic effect.)

In recent years another legal intervention has received notoriety in cases involving prenatal conduct: criminal prosecution of women for using controlled substances during pregnancy. To date, the courts have been reluctant, absent express state law to the contrary, to hold women criminally culpable for such behavior.

The ABA Center on Children and the Law is sponsored by the American Bar Association's Young Lawyers Division. The Center began in 1978, and today has over 24 attorneys, social science professionals, staff and consultants working on, among other things:

- child abuse and neglect, civil and criminal court issues
- foster care and family preservation
- child welfare legal training and curricula development
- parental child abduction research
- child maltreatment fatalities technical assistance
- child support training and technical assistance
- publishing the *ABA Juvenile and Child Welfare Law Reporter*, *Children's Legal Rights Journal*, the *Child Support Prosecutor's Bulletin*, numerous publications, and
- parental substance abuse and child protection

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There is a federal law analog to state torts: section 1983 of civil rights actions. Under a civil rights law suit, certain actions by a defendant that have tort-like qualities may be pursued by alleging that the wrongful conduct violates a constitutional right. For example, it may be argued that a foster parent who molests a foster child could be guilty of either the tort of assault or the civil rights violation of the child's due process liberty interests.

Where are personal injury suits brought? Tort actions are brought in state courts. Civil rights cases may be heard in a state or federal district court. As court dockets and attendant delays grow and the cost of litigation increases (it may take years to litigate civil tort actions, as criminal cases take precedence in most courts), alternative dispute resolution has gained in popularity. Many state courts and bar associations have developed special programs, such as Settlement Week and Multi-Door Courthouses (court which is designed, through intake and other means, to facilitate the use of alternative dispute resolution) to encourage mediation or non-binding arbitration in a variety of tort matters.

Who are the litigants? Torts actions are suits between individuals, between agencies/corporations, or between individuals and agencies (special rules often govern suits involving government officials or agencies). In civil rights suits, the defendants are typically state employees and/or public agencies.

When the alleged injured party in a tort action or civil rights suit is an infant or child, he or she is the plaintiff to the action. However, since our legal system deems minors incompetent to press their own law suits, such actions must be brought by a parent, "next friend" or guardian ad litem. Non-parent next friends are particularly important in cases where a parent is the defendant or where the parents' and child's interests may conflict.

Another type of plaintiff may exist in a civil rights suit: a class of similarly situated individuals. In class action law suits, the court certifies a class of plaintiffs, for example all children in foster care or children who have been denied SSI disability benefits, if the court is satisfied that the group has common grievances against the defendant and that a representative sample of the class (the "named plaintiffs") can adequately and fairly represent the interests of the entire class. Unlike actions brought by individuals seeking monetary damages, class action lawsuits often seek injunctive relief whereby a court orders the defendant agency to cease or reform certain practices.

Infant/family professionals and the justice system

Service providers who work with infants, toddlers, and their families can play a range of constructive roles in the kinds of dispute resolution described above. Roles will vary depending upon the nature and stage of the dispute and the relationship of the service provider to the child and family.

The informant role: The service provider may be an **observer**, **developer** or **interpreter** of information.

During their typical interactions with a child or family, practitioners may observe behavior or conditions of the parents or infant that will shed light upon the dispute at hand. For example, a child care provider may see that a toddler is not adequately clothed to protect her from cold weather, or a neonatal nurse may note behaviors of a newborn suggestive of drug exposure.

As a developer of information, the professional may observe, test or evaluate the parent or child in a clinical procedure or setting to ascertain mental, physical, cognitive, and developmental capabilities. Such an evaluation may take place in the normal course of business, without litigation in mind (as in developmental assessment that is part of the preparation of an Individualized Family Service Plan), or it could be part of the litigation strategy, especially requested by the court or by a litigant (as in an assessment to determine which parent is better able to care for an infant).

As an interpreter, the professional may be given the results of tests or a narrative of the observations of others and asked to form an opinion about the child or family. The professional need not have personally seen or tested the child. Such opinions are routinely sought in day-to-day practice—second opinions or professional consultation—or may be obtained for litigation purposes.

The witness role: When a dispute becomes intractable, and the justice system is invoked, the professional may be asked to be a witness—that is, to provide background information or to testify formally.

Background information may be given voluntarily to the litigants, or it may be compelled through the process of legal discovery, whereby litigants, prior to a hearing, may seek relevant information in the possession of their adversaries, including their adversaries' potential witnesses. Rules of discovery control how this information is shared, and to what extent. These rules vary by type of procedure and state. In general, the more formal the dispute resolution format, the more information or discovery a litigant is entitled to obtain from the other side.

In discovery proceedings, an attorney may "depone" a professional witness (taking testimony, out of court but under oath, prior to the litigation), or may examine the professional's records. The potential conflict between the professional's need to maintain a client's confidence and the justice system's need to ascertain the truth poses serious ethical and practical dilemmas. The dual role of clinician and witness is a troubling one, with no easy rules or solutions. Statutory rules of confidentiality and privilege limit discovery to some extent, but contain numerous exceptions. To the extent that generalizations may be made, the justice system's need for information tends to override traditional rules of professional confidentiality when the well-being of a young child hangs in the balance—but not always.

In courtroom proceedings, professionals may be called as lay or expert witnesses. For the most part, testimony that merely relates observations is the domain of a lay witness. No special expertise is required; the witness must simply

be able to recall and relate his observations, and be truthful in doing so. In many ways, such testimony is the most powerful. It helps to paint a picture of the family/child and is offered by an impeccable source: a professional who made the observation without litigation in mind.

Testimony based on tests and/or interpretations of tests and observations of others requires demonstration of professional competence and expertise. In expert testimony (see Pruett, this issue) a professional who is recognized as an expert is allowed to state his or her opinion on an issue about which the fact finder (i.e., judge or jury) needs assistance.

In some cases, such as SSI disability eligibility disputes, the testimony (which may be by written submission) of a physician or mental health professional may be essential. Yet many fact-finders look with some suspicion upon experts, especially those engaged expressly for the purpose of litigation. Such experts may be thought of as "hired guns;" the opinions of opposing, dueling experts may negate each other.

The imposing halls of justice, unquestionably, intimidate. The legal jargon, formalistic rules, and judicial

tapestry can unnerve the most stalwart. Yet families and the many professionals who serve them need not feel powerless. In recent years, through the development of alternative dispute resolution programs, efforts to restore "plain English" to legal documents, and the growth of special interest and poverty law programs, the justice system has become more responsive to citizens' needs, although much more could still be done.

Professionals concerned about families may seek guidance from these specialized law programs. They range from local legal aid offices (who represent indigent clients, often in the benefit, family dysfunction, and family dissolution areas discussed above) to special state, regional and national programs. These programs may be devoted to special interest areas, such as mental health (for example the Mental Health Law Project in Washington, D.C.), or to the overall interests of children and families. The ABA Center on Children and the Law is just one example of a national program that offers information and education for professionals who interact with the justice system. ♦

Bearing Witness for Babies: The Role of the Expert Witness

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Faced with the daunting, and usually unhappy task of deciding which available course of action may do the least damage to young children and their families, America's courts are turning increasingly to "expert witnesses." Serving as an expert witness—either as an expert observer or as an expert giver of evidence is rarely satisfying clinically. This work is not for everyone. Yet infant/family practitioners who do bear witness for babies within the justice system have a unique opportunity to assist and educate judges, attorneys, and other professionals who are struggling, as we are, to improve the quality of life for children whose nurturing domains have collapsed, or who are caught in systems of competing values of care and protection.

Clinicians must remember that the courtroom is a forum for the resolution of legal disputes, not for clinical intervention or for the display of erudition. Moreover, all too many adjudications affecting young children involve an adversarial process in which only one side will win and others lose. Consequently, it is usually inappropriate to speak of the "best" interest of the child (which most of us would agree consists of being raised by two people who bring the child into the world and feel abiding emotional responsibility for his well-being and survival), as that is usually a casualty by the time a case comes to court. Yet if we infant/family professionals can adhere well enough to the court's rules, we can use our hard-won clinical expertise to improve significantly the chances for reasonable resolution for specific children and families. We can also

occasionally enhance the court's capacity to serve children and families in general.

The business of bearing witness for babies—as opposed to pre-schoolers or children in general—is a special variant of advocacy. When the human beings who are the court's principal concern are babies, they quite literally cannot "speak for themselves." They cannot present evidence, bear witness, cross examine, or contradict evidence brought into court by the people who purport to love and understand them best. Thus our capacity as clinicians to understand the inner life of the very young child and to articulate it in a useful manner is vital. Without such empathic representation, a court is, quite simply, not likely to give as much weight to an infant's needs as it gives to the needs of others.

Most experts do their forensic (law-connected) work as part of a larger professional identity or commitment. The nature of a contract between a clinician and a court or attorney differs significantly from our usual alliances with families and their infants or toddlers. Different rules also govern evaluations and the provision of written and oral reports. While there can be no substitute for specific training and ongoing mentorship as preparation for the role of expert witness, I hope through this essay to offer a useful beginning guide to key aspects and challenges of the work.

From initial contact to investigation

The transformation of a clinician into a forensic agent often occurs faster than one might expect. Beginning with a phone call or a letter, the contract to serve is shaped

by each succeeding communication between the clinician and the family or the officers of the court. Because the rules that govern this contract vary significantly from the typical therapeutic contract, they must be consciously articulated by the clinician throughout the evolution of the investigation. If you wait until the end of the opening discussions with an attorney to discuss your role, it is probably too late.

I have found my own clinical usefulness in legal matters to be directly proportional to the number of people who support my involvement with the issues. Thus when I am appointed by the court, rather than hired by one adversary to face off against another, my expertise is of greater use to the court. My motivation as a court appointee is more clearly tied—in other's minds as well as my own—to the well-being of the child.

The flow from initial contact to investigation typically proceeds in four stages:

1. **You make it clear to the attorney or court that it is your time and expertise that are being contracted for. You will be paid for your time and expertise, not for your opinion—that is not for sale.**

2. **You make it clear that the objectivity essential to reasonable clinical practice will not be compromised. Therefore, you will insist that all available relevant information will be supplied to you, whether or not it is helpful to a particular attorney's client.** You must be vigilant at this point, as the adversarial nature of many court proceedings encourages a representing attorney to present you only with information that seems favorable to his side. Yet if an expert evaluation is to be worth anything to the court (and to the child), it must be scrupulously objective and fair.

The issue of objectivity may first arise when you say that you must (with rare exceptions) see all of the important people affecting a child's life in a particular case. At this point, the attorney will understand that she cannot buy your opinion, and that by dealing with you she is running the risk that the court will hear an opinion that may not be favorable to her client's position. This realization marks the end of many evaluation contracts, most of which fall into the Good Riddance category.

3. **If the court or attorney can define the area of inquiry clearly and if the issues fit comfortably within your area of expertise (you must guard against the temptation to claim additional professional territory), it is time to agree upon the form and cost of the evaluation.** By and large, attorneys are less conflicted about discussing fees than are clinicians or even clinics. You can learn more about the value of your time in this work than in many other professional endeavors. Remember to discuss a timetable, too.

4. **Arrange for an orderly exchange of important documents.** Your curriculum vitae and any supporting documentation regarding your expertise are key. Relevant review articles on specific diagnostic or clinical syndromes

or dilemmas may be useful here, especially if they can inform the attorney or the court about the specific clinical matters at hand.

Infancy clinicians as witnesses for babies

The "clinical" problems involving infants, toddlers, and their families which are brought to the adversarial setting of the courtroom usually have to do with matters of custody, termination of parental rights, or the impact on the child of the relocation of one of the child's biological or nurturing parents. In addition, a court may call on an expert witness as it considers the reliability of a child as a witness, or as it seeks to balance (or challenge) the testimony of another child advocacy agency.

Unique opportunities and dilemmas face the infancy clinician who feels (or has in fact been) compelled to bear witness for the very young child in this context. Consequently, several key attributes distinguish such clinicians from other witnesses before the court.

1. **We have a special, compelling capacity to communicate our convictions about children and infant mental health.** Many of us have been in practice for awhile, have spent considerable time and money in training, and feel fortunate to be working in a field that brings a level of personal satisfaction (along with a level of personal commitment) beyond that typically found in professional life. When you are involved with attorneys and courts, let your convictions show.

2. **Our expertise and concern remain focused on the young child.** As expert witnesses, we are called upon to deal with a plethora of experts and agencies who already have been involved in the life of the child through a variety of events and circumstances, both happy and unhappy. We can appreciate their experiences and perspectives while continuing to use our convictions about children and infant mental health as navigational aids through these troubled and crowded waters.

3. **We are often asked questions which may be similar, if not identical, to the question before the judge—but we cannot do the judge's job, or vice versa.** Potential confusion of roles is most likely to occur in matters involving custody or termination of parental rights. This may raise our anxiety, or stimulate our grandiosity. It is appropriate for the infant/family practitioner to discuss best practice, to describe, on the basis of his evaluation, the developmental strengths and vulnerabilities of a particular child, and to describe the kinds of caregiving environments and relationships that are likely to support the healthy development of this child. What is not appropriate is for the expert witness to answer the question "Should Suzy spend every other weekend with her father?" if that is the question before the judge.

4. **When interacting with the justice system, we have an excellent opportunity, as well as a deep responsibility, to inform the court about the bedrock**

issues on which we rest most of our clinical opinions, observations, and judgments. These include:

- the overriding significance of human relationships to the well-being and development of the child;
- the fundamental need for consistent, continuous caretaking relationships for the infant;
- the inextricable intertwining of environment with endowment;
- the maturational forces which shape a child's life over time;
- the differences between the way children perceive their world and the way caretaking and other adults see the world;
- specifically and importantly, profound differences between the child's and adult's sense of time; and
- children's innate desire to be competent and attempt to master the world about them.

These concepts are far from givens in the minds of most jurists.

5. **We understand and can articulate the importance of the way in which children are loved and cared for.** No clinician should assume that everyone in a courtroom understands that how infants form attachments with nurturing people in their lives is more important than, for example, the floor plan of a house, economic advantages, parental intelligence, or religious, ethnic, or cultural traditions. Courts must be reminded repeatedly that just because a person is feeding, clothing, diapering, or attending to the physical needs of a child does not mean that she is doing these things lovingly or with understanding, or that he is responding to the unique characteristics of the child in this relationship. Courts do not automatically understand that the way children are loved and cared for profoundly affects their faith in the world as a whole and their decision to become contributing members of the human family. It has been my experience, however, that when I am able to articulate these matters clearly, the courtroom generally quiets noticeably, and attention becomes focused on the persuasive truth of what I have to say.

Forensic investigations

Bank and Poythress (1982) have discussed the pros and cons of court testimony and forensic reporting by mental health professionals. They have articulated carefully the dramatic differences between the usual clinical investigation and the forensic clinical examination: the latter must consciously and expressly address relevant legal issues. Within this framework, the clinician's responsibility is to conduct the evaluation and present information in such a way as to keep the child at the center of the court's concern.

Forensic investigations take differing forms, depending upon the questions posed by the legal issues. If you have agreed to serve as an expert in a particular area, you may not need to see every major player in the child's life. If the area is sufficiently discrete (e.g., the effect of maternal

substance abuse on fetal development), you may not even need to see the child.

Most investigations, however, are complex. From the beginning, you must be scrupulous in informing all parties about the nature of the investigation and the ultimate fate of information that is shared with you. Since the methods you use in a forensic investigation are similar to those you use to learn about a patient or a client as you build a therapeutic alliance, you must avoid implying that your empathic tools are being used solely for the immediate and direct well-being of the person interviewed. Inexperienced clinicians are particularly likely to find themselves careening back and forth in their opinions during the course of the investigation, depending upon empathic connections. It helps to remind yourself of Goldstein, Freud, and Solnit's conceptualization (1973) of a forensic investigation: The final goal here is the least worst alternative for the child in the question before the court.

The forensic report

After you have concluded your evaluation and (one hopes) reached a decision on the question you have been asked, it is best to present a brief verbal summary of your pertinent findings to the requesting judge or attorney. A decision may be made at this point about the preparation of a written report. This is a danger zone for many clinicians.

Clinical and adversarial positions are far from identical. Do not assume that any attorney—no matter how competent legally, socially, or personally—understands clinical material or even the intricate process of a forensic examination. Remember also that you and the attorney are operating from profoundly different sets of assumptions and motivations about the clinical material. The attorney is interested in winning. As a clinician, you are interested in trying to convey

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the truth of a child's life to people whose decisions will profoundly affect that life. Although you and an attorney may already be friends, it is unlikely—given the above differences—that you will become professional colleagues with identical convictions and motives. Do not expect it.

And do not be surprised if your consultation is terminated before a written report is sought—especially if your opinion is not favorable to the attorney's client. This is why you discussed fees for time and expertise earlier, with retainers in place—to protect your objectivity throughout the evaluation.

If you are asked for a written report, you will want to spend time on it, for many reasons. A compellingly argued, clear, articulate report may save you time in courtroom testimony—a worthy goal indeed. Remember that your written report is a public record: Keep it free of moral judgments and of jargon; assume that it will be seen eventually by all parties involved in the case.

In the Yale Child Study Center Child Psychiatry Training Program, all second-year residents must participate in, and prepare forensic evaluations. We find Melton, Petrila and Poythress' chapter, *Consultation, Report Writing, and Expert Testimony* (1987), a clinically useful and rhetorically consistent guide to the formulation of forensic reports. They suggest:

- Information to be included in a report should begin with the date and nature of the clinical contacts, followed by the data collected and sources of information which informed the report.
- Next comes the circumstance of the referral and the focus of the legal problem.
- A recounting of the relevant information may follow. Be brief, rather than expansive, if you can, but complex histories of previous trauma, loss, evaluation, psychiatric intervention, etc. may require elaboration.
- Summarize your clinical findings, drawing freely upon observation and any assessment instruments employed.
- Summarize overall psychological functioning, ending with a clear diagnosis when necessary and possible.
- Summarize the relevance of the clinical material to the legal issues being decided.

Testimony

Sooner or later, as a developmental clinician dealing with troubled families and their children, you will be asked to testify under oath, either as an expert or as a responsible treating clinician. Ethical problems arise immediately in the latter circumstance. Treating clinicians are at significant risk of falling into role conflicts, eroding therapeutic alliances and their privacy, and becoming trapped in the dilemma of "dual agency"—that is, attempting the impossible task of trying to serve both the court's interest and the child's interest simultaneously, when the latter, not the former, was the reason for the clinician's involvement in the first place.

With only the rarest exceptions, you should not serve as an expert in the interest of the court concerning a child whom you are treating. The probability that you will distort or destroy the therapeutic alliance is too high to risk.

When it is clear that testimony will be required of you, as either an expert witness or as the treating clinician, consult with the attorney who will be questioning you about the nature, extent, scope, and vulnerability to cross-examination of your testimony. However, the rehearsal of specific questions and answers is relatively useless, because the stilted quality of rehearsed answers impresses no one and usually erodes credibility.

You must brace yourself for the alien culture of the courtroom. It is profoundly different from the culture of the consulting room, in that it is primarily interested in the conflict between plaintiff and defendant, not in the well-being of the patient. We encourage clinicians in training to visit courtrooms with senior colleagues or mentors so that they may begin to understand the strange forces at work in this exotic place.

Once you are sworn in, you must face the *voir dire* (from the Old French, "saying of truth"), the preliminary examination of a prospective witness to ascertain his competence. In the face of expectable performance anxiety, you may find it helpful to remember that what happens in the *voir dire*—including, at the least, attacks on your clinical judgment—has nothing to do with you personally. This is business. The *voir dire* is a guided journey, designed to articulate for the judge a chronologic history of the clinician/witness's education, training, and foundation for expertise concerning the issues raised by the case before the court. Since expertise in clinical aspects of infant/family development is relatively rare, you may need to establish not only your own authority, based on your preparation and work in the field, but also to explain the field's scientific basis and longstanding validity as a subspecialty. This is no time to demur.

Your testimony itself will consist of two parts: direct questioning and cross-examination. During "the direct," the attorney who engaged you as a witness will lead you through your findings so that they are presented coherently and in a way that is generally supportive of her client's position. Your motives are different and unwavering—you are trying to convey the truth about a child's life, as you see it—but you may need to adjust your communicative style to fit this particular setting. For example, the quiet-but-attentive, active listening that you use in the consulting room is appropriate for the witness stand only when you are being questioned. When you speak, trying to express a jargon-free understanding of the complexities of the inner life of the young child, you must be authoritative and articulate. Address your remarks largely to the judge, using eye contact and reciprocal awareness of the judge's attention.

During direct questioning, you will be reminded that the court's job is to attempt to arrive at a just decision by adhering to certain rules of evidence that regulate the admission of findings and data to the court's consideration.

Be mindful that your considered opinion, based on a bedrock of scientific methodology, impresses the legal system (and assists the judge) not at all—unless your opinion is articulated well and entered as evidence in the proper fashion. The process of direct questioning will also make you aware of the various personalities involved in the case at hand. The opposing attorney will probably make some objections, which the judge will either allow or overrule, thereby either discouraging or encouraging you in your task to enlighten the court about the needs of this particular infant. Remember that judges and attorneys vary in their temperament as much as the infants and young children who are the usual focus of your concern.

Cross-examination, the second phase of testimony, is the unique aspect of testifying in court. The closest you are likely to have come previously to the somewhat pugilistic attitude of a cross-examining attorney is that of an irate parent or family member whose aggression, having to do with his own psychological makeup or the clinical problem at hand, is nevertheless focused on you. Rosen's (1991) militaristic imagery is quite appropriate as he calls cross-examination a "weapon in the lawyer's arsenal" within the adversary system. The attorney uses cross-examination to attack the witness, or to turn the witness himself into a weapon directed at the adversary.

Of course, your role as a witness is not to be an adversary but, rather, a "representative in court of the commitment to the truth ... required to treat the examination as a search for truth" (p. 1152). Whatever the cross-examining attorney's intent, you may well experience cross-examination as an imperious attack on your integrity. It is important—as you would with an aggressive patient—to absorb the aggression, refrain from responding in kind, and keep a level head. You are the expert here, not the attorney, and your knowledge is your defense in this process. To quote Rosen again:

Fact finders in court evaluate an expert's conclusions by how the expert has handled the tension between the aggression of the cross-examiner and the witness's obligation to speak for scientific truth (p. 1154).

It is my impression that developmentally trained clinicians often manage "cross" rather well, avoiding defensiveness and reciprocal hostility. Perhaps this is because we are accustomed to dealing calmly and appropriately with normal aggressive exploration by autonomy-seeking young children.

A review of some common pitfalls in giving testimony seems useful here.

- **Avoid lengthy verbal treatises on, for example, the exigencies of linear versus noncausal infant development.** Examination and cross-examination are not invited lectures.
- **Guard against professional arrogance.**
- **Avoid jargon.** This is likely to be easy for clinical infant/family professionals, since we have so much experience speaking to families and children in a very

direct manner about the most complex difficulties that we usually develop a simple yet compelling vocabulary to explain cause, effect, and vulnerability. This is as useful in court as in the consulting room.

- **Do not over-advocate your hard-won opinion.** I frequently must stifle the temptation to expand on a particularly cherished formulation.

But finally, be of good cheer. The skills and predispositions that inclined you toward infancy work will be useful to you in the forensic process. During direct testimony and cross-examination, your patient listening, observation of affect, and avoidance of aggressive response or premature closure on understanding intent or content will be valuable tools.

Concluding reflections

In closing, I offer some reflections upon the obligation to train clinical child development specialists in forensic consultation. The value of an experienced senior clinician's mentorship cannot be overemphasized, since performance is as important as content if testimony is to be persuasive. Unless an individual has had some experience in the performing arts, debate, or public speaking, it is unlikely that her clinical work will have prepared her for the bizarre events (and expectations) of courtroom life. Consequently, training for forensic consultation should require reading legal cases, open and frequent discourse with attorneys, mock trial work whenever possible, critiquing of transcripts, and attendance at a trial.

Additionally, we must be conscious of the seductions of collegiality in forensic consultation. The loneliness of this work for the developmental clinician may tempt him to use, seek out, or be entrapped into using the attorney as a friend or co-worker in this process. This cannot be the case. The attorney is interested, legitimately so, in winning. The clinician must be interested solely in the child—he may be the only real, informed advocate for the child in the adversarial setting.

Good infancy clinicians often make good forensic consultants. In fact, I would guess that one is unlikely to become an adequate or persuasive forensic consultant, especially in the area of development and experience in the earliest years, if one is not first a good clinician. Forensic work is not for everyone. But it often contains unique satisfactions, and its frustrations are laced with creative worthiness that improves more lives than one might guess.

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Kinship Care: Developing a Safe and Effective Framework for Protective Placement of Children with Relatives

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On December 31, 1986, there were 45 children in New York City living in a newly created form of foster care known as "approved relative homes."¹ By December 31, 1991, there were 23,591, or well over half of the total children in family foster care.² In five short years, the exception had become the norm.

In other urban areas as well, a similar surge has occurred in what has come to be known as "kinship care," the official placement of children with relatives as a form of foster care. In Philadelphia, for example, which began regularly making kinship placements only a few years ago, relative homes comprised of 67 percent of the total foster care homes by March 1992.³ In Chicago, 57% of all new foster care placements made in 1989 were placements with relatives.⁴

Existing federal and state foster care legislation and policies, developed almost entirely with non-relative care providers in mind, are now being applied en masse to relative providers. Yet laws and policies designed for use with non-relatives may not effectively serve children placed with relatives—and may even have unintended negative effects.

This article discusses some key issues which must be addressed by federal and state legislators, child welfare administrators and advocates if children, parents and extended families are to be adequately served. Its focus is the appropriate legal, fiscal, and service framework for kinship care cases, when the relative has been selected as an appropriate placement resource. (It does not address the related issue of how the initial determination should be made as to whether a certain relative is appropriate.)

The role of relatives in families under stress

Care by relatives in times of family difficulty is a time-honored American tradition. As stated by Supreme Court Justice Powell, "Ours is by no means a tradition limited to respect for the bonds uniting the members of the nuclear family. The tradition of uncles, aunts, cousins, and especially grandparents sharing a household along with parents and children has roots equally venerable and equally deserving of constitutional recognition." *Moore v. City of East Cleveland*, 431 U.S. 494, 504 (1977) (upholding the right of grandparent and grandchildren to live together in the face of contrary zoning laws.)

In part, the recent growth in kinship placements reflects a growing consensus that an appropriate extended family placement represents the best possible choice for a child removed from parents, and that the child welfare system should not unnecessarily disrupt families, communities, and cultural ties. At the same time, it also reflects the fact that the number of children in need of foster care has itself mushroomed in recent years, and an adequate supply of foster parents is simply not available in most areas.

In recognition of the positive role that extended family can play in raising children, it has long been standard child welfare practice in protective cases to encourage overwhelmed parents to turn to relatives as needed to relieve family stress. In some cases, this might lead to a voluntary placement of children by a parent with a relative. If the placement with the relative appeared to resolve the child protection problems, such that the children were no longer at risk, the case might be closed. In some cases, in fact, a child protection case might never even be opened, if the parent immediately agreed to place the children with a relative, and the caseworker was satisfied that the matter was resolved.

Laws and policies designed for use with non-relative care providers may not effectively serve children placed with relatives—and may even have unintended negative effects.

To describe most placements with relatives in child protection cases as purely "voluntary", however, would be misleading. A caseworker may "advise" a parent to consider placing a child with a relative, but both parent and relative know that the alternative may be a court action by the agency to gain custody and place the child into foster care. So the agency may, practically speaking, be intervening and initiating a parent-child disruption—yet in a manner that is informal, unregulated, and undocumented. Since the state does not legally assume custody, and the placement is not an official foster care placement, the state may assume that federal and state legal protections regulating the placement of children in foster care do not apply. Indeed, if the case is soon thereafter closed, the agency will not even know if the placement with the relative will continue, much less benefit the child.

While some states continue informally to urge placement with relatives in protective cases, without assuming custody or regulating the placement, other states have moved toward a more formal legal model. It is this more formal model which is generally termed "kinship care." While the specific legal and financial arrangements vary by state, kinship care generally refers to cases in which 1) custody has been assumed by the state, either by court order or parental consent, in response to substantiated allegations of parental abuse or neglect, and 2) the child is placed by the state with a relative or close family friend, or the state officially approves an existing arrangement by which the child lives with a relative or close family friend. Because the state has assumed custody, the protections of the federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) apply, whether or not the state pays foster care reimbursement to the kinship caregiver.

Thus, a state which has for many years routinely urged informal, extralegal placements with relatives as a way to *avoid* foster care placement may shift to a practice of formally making kinship care placements as a *type* of foster care placement. While care by relatives does appear to be increasing generally, states with the most dramatic increases in documented relative care may be states in which past informal placements with relatives were not documented—but more recent formal kinship care placements are.

The shift from informal to formal placement with relatives is not a mere accounting change, however; it has serious practical and legal impact. What we don't know is whether the change is, on the whole, positive or negative. Children in protective cases who are placed informally may face all the risks that P.L. 96-272, and other federal and state protective legislation, were designed to avoid: lack of permanency planning, lack of services to the parent and other family members, lack of any needed preplacement screening or post-placement supervision, and so on. Yet relatives designated as foster care providers may face regulations and policies far more suitable to non-relative providers than to relatives, such as square-footage requirements for their homes, training designed for professional foster parents, and even income or marital status requirements. The state may face difficult policy choices between under-protection and overintrusion, as well as challenges in allocating resources between parents and kinship caregivers.

This dilemma reflects the central problem noted above, that the legislative framework of the foster care system, in general, was developed with non-relative foster care providers in mind. Some provisions may conflict with extended family needs, while others are crucial to parental rights and child safety in all protective cases. A crucial task of legislators, program administrators, and child advocates, on both the state and federal level, must be to identify and develop laws and regulations specifically designed to promote child welfare in the extended family context. This article will explore some relevant issues and options to consider.

The federal/state framework for services to families

Services to children and their families in protective cases are administered by the states, but are regulated and partially funded through several federal child welfare programs. Major federal programs, and their potential impact in kinship care cases include:

- Title IV-A of the Social Security Act reimburses states for Aid to Families with Dependent Children (AFDC) payments made to families. While AFDC is not aimed at protective cases, many families in protective cases do qualify for AFDC on income and child dependency grounds. Parents caring for their own children must meet state income eligibility requirements to qualify for aid, while a relative who has assumed the full-time care of a child or children may receive aid if the child qualifies. In general, AFDC payments are much lower than foster care payments under Title IV-E, described below. Title IV-A is an open entitlement program;

federal expenditures in fiscal year 1991 for AFDC benefits were \$11.1 billion.⁵

- Title IV-B of the Social Security Act authorizes funds for states in a range of child welfare services, which may be used to assist children and families without regard to income levels or custodial status. There are no major provisions relating to care by relatives. The program is a discretionary authorization, with appropriations in fiscal year 1991 of \$274 million.⁶

- Title IV-E of the Social Security Act reimburses states for monthly payments made to foster parents of children in state protective custody, and for adoption subsidies to support the permanent placement of hard to place children. To be eligible for federal reimbursement, a child must have met financial and other eligibility requirements of the AFDC program prior to foster care placement. The IV-E provisions neither mention nor exclude relatives as caregivers in either category. The program is an open entitlement program; total fiscal year 1991 expenditures were \$1.8 billion, including \$1.0 billion for reimbursement of payments to foster care providers.⁷

- The Title XX social services block grant provides funds to states for a wide range of social services, including child welfare. There are no special provisions relating to kinship care. Title XX is a capped entitlement program, with an entitlement ceiling of \$2.8 billion.⁸

Within this context, states face difficult choices in serving families in kinship cases. Use of Title IV-B and Title XX funds allows the greatest degree of state flexibility in administration, but neither is an open entitlement, and each addresses an extremely broad range of state service needs. This means that funds are more limited, and that any expenditures must be balanced against other state social service needs. For these reasons, Titles IV-B and XX have not emerged as a major resource for serving families in kinship care cases.

This limits the ability of states to provide federally reimbursable *services* to families in kinship care cases. There are, however, two alternatives for providing federally reimbursable *financial assistance* to the kinship caregiver in meeting the children's needs. In some cases, relatives receive AFDC payments for the children in their care (reimbursed under Title IV-A). In other cases, the relative caregivers receive foster care payments (reimbursed under Title IV-E). Even within one state or county, some kinship providers may receive only AFDC payments (or no assistance at all), while others may receive foster care payments.

The eligibility of kinship caregivers to receive federally reimbursed foster care payments

Several factors influence which form of financial assistance—AFDC or foster care payments—will be provided to kinship caregivers. Understandably, given the low levels of AFDC awards, and the fact that children placed in protective cases often come in sibling groups and have serious

special needs, many relatives seek the higher foster care payments. Also not surprisingly, given state fiscal concerns, many states have sought to avoid paying relatives the full foster care rate, urging relatives instead to accept AFDC.

In the case of *Miller v. Youakim*, 440 U.S. 125 (1979), the U.S. Supreme Court ruled upon the most extreme aspect of this conflict. The state of Illinois had, as a matter of state regulation, explicitly excluded relatives from becoming foster parents of the relative children. Noting that the cases before the court were IV-E reimbursable cases, and therefore governed by the IV-E provisions, the court held that the lack of federal language excluding relatives barred the state from implementing such an exclusionary policy.

Should the state waive foster care requirements not appropriate to relatives, or design new requirements specifically for relatives?

Miller v. Youakim thus prohibits arbitrary discrimination against relatives who seek to become IV-E reimbursed foster parents, but it does not address the many practical barriers which may arise in kinship cases. For example, suppose the available relative is selected as the best possible placement alternative for a child in state protective custody, but does not meet state requirements for foster parents (e.g. because the home lacks an extra bedroom, or the application process takes several months). Should the state decline to place the child with the non-qualifying relative, even though the relative offers the most nurturing alternative? Or may the state place the child with the relative, but refuse to pay the foster care payment, since the disqualification is not based upon the mere fact of being a relative? Alternatively, should the state waive requirements not appropriate to relatives, or design new requirements specifically for relatives? Finally, should the state maintain existing foster care standards, but assist relatives in meeting them (such as by providing housing assistance, or a quicker approval process)? The case is silent on these crucial policy questions.

In states which follow only the minimum requirements of *Miller v. Youakim*—that is, not discriminating against relatives if they otherwise qualify as foster parents, but not assisting or facilitating them in becoming foster parents if practical impediments exist—an ironic and unintended effect may result. A relative with the financial and family stability to meet state foster parent requirements, and the assertiveness to pursue the process, could probably receive the higher level of benefit provided by foster care payments. A more impoverished and disorganized family, however, who cares for the child in the protective case but doesn't meet state foster parent standards, might well be restricted to the much lower AFDC payments. Equally ironic, the more stable family would likely be subjected to foster care supervision, while the possible less stable family (tracked only

as an AFDC case) would have little or no protective supervision. In effect, the less needy family would receive more, in terms of both financial assistance and supervision, while the more needy received less.

Some states, such as New York and Illinois (in both cases, under pressure of suit by relative caregivers), have responded to this apparent inequity by instituting special procedures for approving and reimbursing kinship caregivers as foster parents. Under these procedures, some basic safety factors (such as criminal record checks and fire safety standards) are applied to relatives, while others (such as home square footage requirements or foster parent training requirements) are waived. Once specially approved, the kinship caregiver receives the same level of financial assistance that any other foster parent would. Federal protections under P.L. 96-272, such as reasonable efforts to prevent placement and permanency planning, are extended equally to children placed with kinship caregivers or non-related foster parents.

Such efforts by states show admirable innovation, but problems remain. Kinship caregivers are assisted with much needed financial support, but the payments disappear when the children return to the parents. Since the difference between foster care payments and AFDC is substantial—in some cases, dictating a drop in total extended family income of as much as 50 to 75 percent when the children return home—this may significantly discourage reunification. At the same time, service supports which could conceivably assist the kinship caregiver and, when the children return home, provide much-needed stability (such as daycare, after-school care, respite care, in-home parenting aides, or family counseling) remain more difficult for states to afford under the federal funding guidelines. In effect, a situation is created in which practical services which could facilitate parent-child reunification are not provided—and a potential financial disincentive for such reunification is created. While undoubtedly not the only reason, this situation may well contribute to the fact that, in both New York and Illinois, children in kinship care tend to remain there significantly longer than children in foster care.⁹

Legally classifying kinship caregivers as foster parents may create other problems as well. Again, this occurs because legal requirements designed for use when children are in foster care with non-relatives may not fit their needs in kinship placements. For example, shifts of residence by children over a period of years between a parent and grandparent, or an aunt and a grandparent, might not be considered an acceptable "permanency plan" under the requirements of P.L. 96-272—but for some families, it might be the best reasonable solution. (Although not ideal, it can perhaps be compared with upper-middle class divorced parents who share custody over time.) Similarly, regular monitoring of a non-related family providing foster care may be appropriate, but it may be inappropriately intrusive in some extended families. On the other hand, federal law, and the law in many states, does not specifically address the special challenges faced in some kinship cases, such as whether and how parental visitation should be supervised

when the parent is a family member. These and other issues specific to kinship care should be addressed.

Possible state remedies

Although states must conform to the requirements of P.L. 96-272, they may administer and regulate their child protective programs in accordance with state policy goals as well. There are areas of possible state improvement, even under existing federal law. The suggestions which follow exemplify the range of options available.

The *Miller v. Youakim* case, as stated above, establishes that relatives who otherwise qualify as foster parents for children in IV-E reimbursable cases must be permitted to become foster parents. The case does not establish standards, however, for three classes of cases: 1) cases in which the relative is an appropriate caregiver, but does not meet state foster parent requirements, 2) cases which are not IV-E reimbursable, and 3) cases in which the relative voluntarily chooses to forgo foster parent benefits, perhaps to participate in a program specifically designed for kinship providers. In all these cases—which may together constitute the majority of kinship care cases—the state has considerable latitude in designing an innovative program.

A strong kinship care program should include both financial and service supports.

One immediately obvious question is how to avoid the apparent burden upon reunification noted above. The best approach is equally obvious: to raise AFDC levels so that children are well supported within their own homes, and the disparity between AFDC and foster care payments is less extreme. Child advocates must continue to strive toward this goal; in the meantime, states will need to design kinship programs with particular care, so that the inequities are not exacerbated.

It may be argued by some that the conflict should be resolved by restricting kinship caregivers to the low AFDC rates whenever the higher rate is not mandated by federal law. This approach, however, is unrealistic and could be harmful to many children. In fact, the family need is especially great when children (often in sibling groups and with serious special needs) must be taken into care suddenly and unexpectedly by relatives (who may have other family responsibilities as well). Absent suitable support, many relatives simply could not responsibly accept the children into their care, however much they loved them and wanted to help.¹⁰ The children would lose the opportunity for the most nurturing environment available—and the state would not even save money, since it would then have to pay for foster care.

Accordingly, a strong kinship care program should include both financial and service supports. Payments to the kinship caregiver should be adequate to meet actual

Kinship Care: How Well Is It Working?

Existing research cannot alone tell us what laws and practices best promote healthy and successful kinship placements. What it can do, however, is to provide considerable insight into the welfare and needs of many families using kinship arrangements today. The following resources are useful references for understanding both the promise and the challenges of kinship care.

Jesse Lemuel Thornton's dissertation, *An Investigation into the Nature of the Kinship Foster Home*, (1987) is available through University Microfilms, Inc., PO Box 1764, Ann Arbor, MI 48106-1764, tel: 1-800-521-3042. The study is based upon interviews with 86 social workers and 20 kinship caregivers, as well as the review of 95 case records. An interesting finding was that kinship care, while often viewed as challenging and problematic in terms of agency/family relations, was widely viewed by both social workers and family members as being "good for the children," less stigmatizing than foster care, and supportive of family preservation.

Howard Dubowitz, M.D.'s *The Physical and Mental Health and Educational Status of Children Placed with Relatives: Final Report*, published in August, 1990 by the Department of Pediatrics of the University of Maryland Medical School, focuses upon the physical, mental and educational status of Baltimore children in kinship care. The study identifies significant and often serious special needs of the children in care, and notes a disturbing lack of appropriate services. While there is no comparison group of children in foster care, some comparisons are made through existing state data. Coverage of medical issues is unusually thorough. The report is available for \$15 from Dr. Dubowitz at the University of Maryland Medical School, 700 W. Lombard Street, Baltimore, MD 21201.

The National Black Child Development Institute's 1989 five-city study, *Who Will Care When Parents Can't?: A Study of Black Children in Foster Care*, included a section on relatives wishing to assist children in foster care. The study is available for \$12 from NBDIC, 1023 Fifteenth Street, N.W., Suite 600, Washington, DC 20005.

While it is difficult to generalize, a few common themes do emerge from much of the existing research. In general, the research tends to affirm that care by relatives can offer substantial strengths, and that a majority of relatives do appear to offer adequate stability and enhanced continuity to the child. At the same time, several studies note serious problems in terms of lack of appropriate services and inadequate case management.

needs, taking into account the financial strain of the sudden, unexpected increase in family size. However, to avoid the problem of a sudden drop in family income when the children return to the parental home, specific practical and service entitlements, rather than just the monthly cash

payment, should be emphasized. For example, the state could provide a kinship care stipend somewhere between the AFDC and the foster care level, but also guarantee specific services such as housing assistance, after school care, and extended daycare. Ideally, as many as possible of these services could remain in place when the children returned to the parental home. In effect, state expenditures which would have gone to foster care payments (had relatives not been available) may instead be devoted to strengthening the extended family, in a way that affirms and invigorates the parent-child bond.

Possible federal remedies

The challenges of serving children and their families through appropriate kinship care practices could be greatly assisted through federal leadership. While current federal law does not bar state innovation in all kinship cases, it does create difficulties in many IV-E eligible cases. Legislation which increases state options for tailoring programs and services to actual child and family needs in all kinship cases could vastly improve program performance, without necessarily increasing program costs.

Tailoring programs and services to actual child and family needs in all kinship cases could improve program performance without necessarily increasing costs.

Several options exist for appropriate federal legislation. One approach would be demonstration project legislation, allowing states to apply for a special waiver of certain requirements and restrictions, and a reallocation of funding resources, in IV-E eligible kinship care cases. For example, a state could propose a program in which kinship caregivers within one county would be selected based upon selection standards specifically designed for relatives, paid a foster care rate somewhere in between the standard AFDC and foster care rates, and receive additional specific services, such as housing assistance, day care, or respite care, which would stay in place when and if the children reunified with the parent. Both the cash payments and the services would be federally reimbursable at designated rates. A research component of the demonstration would develop solid data, providing insight into whether the state's specially designed practices do, in fact, help to safeguard child welfare, promote parent/child reunification, and serve families.

Another more comprehensive approach would be to broaden allowable state options in designing kinship care programs under IV-E, not only on a demonstration basis, but nationwide. The major disadvantage of this approach, of course, is that we may have incomplete knowledge upon which to base an assessment of acceptable options. Before such an approach is rejected out-of-hand, however, it is im-

portant to consider that states are now locked into a framework which we know was not designed for relative caregivers. While it may appear unwise to pass legislation allowing a range of untested options, states are now restricted to options both untested and, as applied to cases involving relative caregivers, basically unplanned. It is at least arguable that, until we have full knowledge of what works, it may be better to allow state innovation, based upon what knowledge does exist. There are some initial studies now complete on kinship care in a few states (see box), and considerable experience and research within the child welfare field generally of extended family dynamics in protective cases.

Related federal legislation

While there is currently no pending federal legislation directly aimed at addressing the needs of children and families in kinship care cases, the possible impact of a related child welfare proposal should be noted. The Family Preservation Act of 1992, passed by both houses of Congress in October, 1992 and vetoed by President Bush shortly after the election, would have provided some help in addressing one issue identified here: the lack of flexible funding for child welfare services. It will not, however, address any of the issues raised under the *Miller v. Youakim* case discussed above.

One proposed provision of the Family Preservation Act does relate specifically to kinship care cases. It addresses an anomaly which, like many discussed here, apparently arose from language originally developed to address non-relative foster care placements. IV-E reimbursement currently is available only for children removed "from the home," but some kinship placements in otherwise qualifying families do not require a physical move by the child. That is, there is an assumption of legal custody by the state, and an assumption of physical caregiving responsibility by a relative acting as a kinship care provider—but the kinship provider and the child already share the same home. The proposed provision would extend IV-E reimbursement eligibility to this class of children in kinship care.

Although the Family Preservation Act does not directly address the policies affecting most kinship cases, it does provide an important precedent. In effect, the Family Preservation Act is aimed at providing services carefully designed to promote child safety and family unity. Appropriate kinship care legislation would similarly be designed to promote child safety and *extended* family unity, while particularly guarding the parent-child bond. Both would help counteract the unintended effects of our current funding system, which tends to provide more federal funding for children who are removed from the parental home, but less to keep the children safe at home.

The opportunity presented

The widespread use of kinship care creates both opportunity and risks for children. If instituted in the framework of specifically-tailored, family-sensitive legislative policies,

kinship care can promote family and cultural unity, while reducing trauma to the most vulnerable children. Less carefully designed policies, however, can undermine parent-child unity, subject some children to risk of harm, and subject some families to unnecessary state intervention into family life. Federal and state legislation now regulates kinship care cases—but the law has developed without sufficient inquiry into its impact on this substantial, important, and growing group of families. An important opportunity exists to serve children, their families and the public with more specifically designed legislation. ¶

Endnotes

1. Task Force on Permanency Planning for Foster Children, Inc., "Kinship Foster Care: The Double Edge Dilemma," October 1990, p.20.
2. New York State Department of Social Services, Child Care Review Service, "Quarterly Summary of Characteristics of Children in Foster Care District Report," February 3, 1992.
3. City of Philadelphia, Department of Human Resources, Children and Youth Division, "Monthly Statistical Report," March 1992.
4. Wulczyn and Goerge, Research Report to U.S. Department of Health and Human Services Office of Assistant Secretary for Planning and Evaluation, "Public Policy and the Dynamics of Foster Care: A Multi-state Study of Placement Histories," December 1990,

p.24; and telephone conversation with principal investigator Robert Goerge.

5. House Ways and Means Committee, "1992 Green Book: Overview of Entitlement Programs," May 15, 1992, WMCP 102:44.

6. *Id.*

7. *Id.*

8. *Id.*

9. *Supra* note 4, pp.21-22.

10. One five-city study of black children in foster care included a useful section on relatives wishing to assist children in foster care. It showed that, in cities in which relatives were not provided with foster care payments, many relatives were unable to assume care of the children. For example, the protective services departments of Detroit and Houston considered the interested relatives as potential placement homes at nearly equal rates (83 percent and 80 percent respectively). However, in Detroit (which provided foster care payments to relatives), 80 percent of those considered actually went on to provide homes to the children; and, among those who did not, none reported lack of financial or housing resources as the problem. In Houston, (which did not provide foster care payments to relatives), only 56 percent of relatives considered as potential caregivers actually did provide children with a home; among those who did not, 27 percent cited lack of financial or housing resources as the barrier. Lack of resources for work-related daycare also appeared to be a greater problem in Houston, as no relatives in Detroit, but 7 percent of relatives unable to provide care in Houston, cited conflicts with employment. National Black Child Development Institute, "Who Will Care When Parents Can't: A Study of Black Children in Foster Care," 1989, pp. 73-76.

Babies in Prison

Jean Harris, *Children's Center, Bedford Hills, New York*

It will be necessary to take into consideration in our institutions, our charitable activities, in our social legislation, the overwhelming and unique importance of adequate and satisfactory mother-child relationships during the first year, if we want to decrease the unavoidable and irreparable psychiatric consequences deriving from neglect during this period.

Rene Spitz, 1945

Nobody knows how many babies were born to incarcerated women in the United States last year. We haven't even a ballpark figure for the past ten years. In the 790-page *Source Book of Criminal Justice Statistics* published annually by the United States Department of Justice, the words "prison births" still don't make the cut.

It isn't because having babies while incarcerated is something new. We know that babies were born to unfortunate women in New York's Newgate Jail in the late 1790s. The first designated prison for females in New York State was a small afterthought, built in 1839 on Sing Sing Prison's back forty, and given the unlikely name, Mt. Pleasant. Before that, female felons had been housed in a single room over the Sing Sing kitchen, fed once a day, and left totally

unsupervised. A matron was hired after a woman, five months pregnant, was beaten to death.

In less than five years, Mt. Pleasant was so crowded as to be untenable. It had a room called "the nursery," but the prison chaplain reported, "the place is bedlam and the early death of the child is inevitable." A child leaving with its mother in 1844 is recorded as "the only instance of a child born in prison up to that time that has gone out alive."

The first full prison built especially for women in this country was opened in Indiana in 1873. Four years later, the House of Refuge for Women was opened in New York State. These two prisons, like The Reformatory for Women at Bedford, which opened in 1901, were not for housing serious felons, only delinquent young women. All these prisons had nurseries—very full ones. Each woman prisoner took her turn caring for the babies whether she had a child in the nursery or not, since mothering, along with farming and housekeeping, were the basic skills deemed necessary to her future.

When Mt. Pleasant closed, women convicted of serious felonies were moved to Auburn Prison for Men. No babies were kept there.

It was not until 1931 that female felons in New York State could keep their babies with them in a prison nursery. Governor Franklin Delano Roosevelt signed into law "Code

611," one of the "Miscellaneous Provisions" of the State Corrections Law. Still on the books, Code 611 permits approved mothers to keep their babies with them in prison until the child's first birthday, or until the 18th month if the mother is to be paroled within that time. Mothers leave the prison facility to give birth and are returned as quickly as their state of health permits.

The prison nursery system today

Today, babies of prisoners at Bedford Hills Correctional Facility are usually delivered at the High-Risk Unit at Westchester County Medical Center because, according to the prison administration, the prior histories of most women include drug use and other activities which place them and/or their babies at high risk during the birth process. Interestingly, premature births and low birthweight babies have been rare among the almost 250 prisoners who have given birth in the past several years. The two Nursery Coordinators recall only one premature birth in the past three years; this was the mother's fourth child, and she said that all her babies had been born prematurely. Even the two sets of twins born in the past three years were full-term, although one set remained in the hospital for two weeks before each baby reached five pounds.

Premature births and low birthweight babies have been rare among the almost 250 prisoners who have given birth in the past several years.

To be considered for the nursery, each pregnant prisoner at Bedford must write a letter of application and be carefully interviewed by a staff member. Every woman must have an alternate placement plan for her newborn on record. The final decision is made jointly by medical and top administrative staff. A woman who is deemed physically or emotionally unable to care for the child is denied. Anyone convicted of arson or serious abuse of her other children is denied. A woman about to have her first child, if fit, is always accepted. A mother with a good record of living with and caring for her other children is always accepted. Wherever there is hope that mother will be the chief caregiver after she leaves prison, an effort is made to keep her baby with her. Women serving long terms are discouraged from keeping the baby, but are not denied automatically.

Some women have trouble understanding why they are turned down for the nursery, or profess to. One woman, the mother of four other children, recently complained bitterly, "They turn me down just 'cuz I neglect my kids. Just neglect. I never hit 'em. Never broke nothin'. Just neglect ain't nothin'. It don't hurt."

Decisions can be appealed. Some are reversed.

In the past two and one-half years, 167 women have been accepted for the Bedford nursery; 66 were denied;

three pregnant prisoners did not apply. Since some women are paroled or transferred before the baby's first birthday, not all babies stay in the nursery for the full year.

Eight years ago, there were seven babies in the Bedford nursery. Today there are 26, and 23 more in a recently opened facility for women directly across the street. There are 50 pregnant women at Bedford, and we are told that there are 150 on Rikers Island, many of whom could end up here. The numbers of women being sent to prison all over this country today give a new immediacy to the subject of prison nurseries.

Having been born in a community hospital, each baby arrives in the Bedford nursery with no mention of his mother's incarceration on his birth certificate. He may remain in the nursery during his mother's good behavior. He can be sent out at any time if his mother seriously disregards prison rules. This rarely happens, but is traumatic when it does. Some partings seem peremptory, some too long delayed. The safety and best interests of the child and of all the other children in the nursery, as well as prison security itself, are the criteria for nursery decisions.

The best interests of the child—insights from Rene Spitz

What is the best interest of the child? There is deep respect here for the importance of bonding and the trauma of separation. Because many women go home with their babies, the nursery helps spare both mother and child the problems and agonies of separation. But in a world of poverty, drugs, ignorance, AIDS, and child abuse, weighing a baby's

BARBARA YOUNG



options is seldom easy. Who might receive the baby outside? Can they do better than the mother? Will they? The answers matter to the child but have deep social ramifications as well.

Taking babies seriously is a relatively new preoccupation among the general public in this country and is still not widespread, although Dr. Rene Spitz gave us fair warning almost sixty years ago that we had better start doing so. Spitz' famous study of the development of 164 infants in four different environments, begun in 1936, was published as "Hospitalism" in the first volume of *The Psychoanalytic Study of the Child* (1945). His findings concerning illness, increased mortality, and developmental delay among the infants who were cared for in foundling homes form an important part of the foundation of current child development theory and practice. Less well known are Spitz' observations about the infants in his study who spent their first year in a Reformatory nursery.

Comparing the backgrounds of the two institutional groups of infants, Spitz wrote:

Reformatory nursery: ... the mothers are mostly delinquent minors as a result of social maladjustment or feeble-mindedness, or because they are physically defective, psychopathic or criminal. Psychic normalcy and adequate social adjustment is almost excluded.

Foundling home: A certain number ... have a background not much better than the Nursery children; but a sufficiently relevant number come from socially well-adjusted, normal mothers whose only handicap is inability to support themselves and their children.

Yet by the end of their first year of life, the nursery babies showed on average a normal and satisfactory development, while the foundling home babies showed startling deterioration.

Spitz' film of infants in the foundling home, some literally dying of loneliness, is deservedly famous. Compare his description of the nursery children:

The problem here is not whether the children walk and talk by the end of the first year; the problem with these ten-month-olds is how to tame the healthy toddlers' curiosity and enterprise. They climb the bars of the cots ... They vocalize freely and some of them actually speak a word or two. And all of them understand the significance of simple social gestures. When released from their cots, all walk with support, and a number walk without it.

That description, written 50 years ago, could have been written this morning to describe many of our prison babies. The main reason for the discrepancy between infants in the two institutions Spitz studied was the presence for each nursery infant of the loving, nurturing care of his mother. Each foundling had to share a nurse with 8 other babies.

The Bedford mothers

Spitz described the nursery mother as "a mother who gives a child everything, and beyond that everything she has." I wouldn't go quite so far in describing Bedford mothers, but certainly most of them, limited as they are in opportunities for sexual expression, the kinds of clothes they can wear, and activities they can enjoy, sublimate their wants by lavishing all they have and can get on their babies. (Though we assure mothers that tiny babies are better off without shoes, no mother will be swayed from her steely determination to see that her baby gets a pair.)

Most Bedford mothers are young, between 17 and 26 years of age, and few come to prison well schooled in the arts of loving, nurturing motherhood. Many did not experience good nurturing themselves, although most will insist that they want to be "as good a mother as mine was." Approximately 30 percent have a high school diploma. About 10 percent of Bedford mothers describe themselves as married; women use the term for both legal marriages and long-term relationships. Being married, however, does not necessarily mean a stable relationship with a father present to help raise the children and pay the bills. For all of these reasons, from the moment they enter the Bedford facility and are medically cleared, all pregnant women are required to enter a parenting class. It is sponsored by the Parenting Center, a prison program, and team taught by a volunteer, a trained inmate, and a Public Health Nurse. Pregnant prisoners take the course whether or not their babies will stay with them in the prison nursery.

Parenting class

The parenting class meets five afternoons a week, from one to three. Lessons are taught on a continuing basis. After two months, classes start over. Women enter and leave the class at different times but complete the cycle. One day each week is given to prenatal and post-partum instruction; three days to child development, infancy through pre-school; and the fifth day to a crafts class in knitting and crocheting.

We never suggest in the parenting class that there is only one right way to raise a child, only that children the world over share basic human needs—and that for infants and toddlers, mother is the most likely to fulfill them.

No one text is used. Women are provided with folders in which they can keep articles from recent publications on the particular subject under discussion. Parts of each article are read in class. We also have a small lending library of books on parenting. Films are widely used. Subjects covered in parenting classes include the physical safety of the child, with emphasis on immunization, household accidents, lead exposure and noise, and the physical, emotional, social, lingual, and intellectual development of the child.

We talk about reading, and let each mother choose a first book for her baby. We spend one class on early finger plays and songs and poems that very little children enjoy. (This is a favorite class, and women ask for extra copies of handouts to send home.) We also discuss discipline, punishment, and child abuse, including prenatal and postnatal use of drugs, alcohol, and cigarettes. We show films of children in different countries and cultures. We never suggest that there is only one right way to raise a child, only that children the world over share basic human needs—and that for infants and toddlers, mother is the one most likely to fulfill them.

After three months, a test is given and certificates of completion are awarded, to give mothers some recognition and a sense of accomplishment. The blankets and booties that mothers have made are displayed. We often hear women say, "My mother can't believe I made anything," or "My mother can't believe I finished something I started."

During one class every month, we give a shower for women who will give birth that month. As gifts, we give them some of the lovely donations that come to us from time to time.

Life in the prison nursery

When her baby is born, the "approved" mother moves with her baby to the nursery floor of the prison hospital. (The babies of "denied" mothers are sent from the birth hospital to grandmother, other family members, an occasional father, or foster care.) The baby's crib is in the mother's cell. Some cells are double the size of regular cells and accommodate two babies and mothers.

While many staff people and outsiders as well insist that a prison nursery is just another way to "coddle" prisoners, it is not especially easy for mothers to be in the nursery. They have little privacy in which to deal with the emotional experience of having just given birth, and the pressures of prison are ubiquitous. I remember a mother saying, "I used to go into the shower to cry. It was the only place to be alone." COs (Corrections Officers) in charge of the nursery floor are given no special training. Some have not been above yelling, "Make your kid shut up," to the mother of a three-month-old. Some COs are very kind. As with so much in prison, it's the luck of the draw.

Unlike almost 50 percent of infants in New York City, the prison nursery babies are all up to date in their immunizations.

Mothers' cultural patterns vary widely, and in close quarters differences can be abrasive. Some strong cultural traditions violate prison rules; for example, it is against the rules for a mother to sleep with her baby in her bed.

The nursery's operating rules change occasionally with staff changes or to reflect new knowledge, but for the most part the daily schedule of the nursery follows the daily

schedule of the prison. The four daily "count times" are the same, except that nursery doors are not locked. However, mothers must be in their cells during count, and after 10:30 p.m. they may leave their cells only for legitimate child care. More than one of our babies have called out "count time" before they spoke other words.

Baby food and disposable diapers are given out weekly; clothing and supplies are given out monthly as needed. Family may send clothing, but toys are discouraged. Ample supplies of toys come through the Parenting Center, and a crib full of toys is neither safe nor allowed. Any form of physical abuse of babies is forbidden and could cause the baby to be "sent out," as could physical fights between mothers. Walkers are not allowed; keeping a baby in a play pen for long periods is discouraged. Mothers may not smoke anywhere in the nursery. In good weather, babies are taken outdoors to their special yard at least once a day. Whenever they leave the nursery floor, babies are accompanied by a CO. Only mothers or babies with medical excuses may opt to remain inside when the group is going out. If a mother is sick, an inmate sitter watches the baby. If a baby is sick, the mother cares for it. All of the common sense rules of mothering are taught and expected to be followed.

While pediatric care is rarely fast enough to please some mothers, it is quite good. Unlike almost 50 percent of infants in New York City, the nursery babies are all up to date in their immunizations, and they have regular pediatric check-ups. Clinical follow-up of potential AIDS is also assured.

Pressures and conflicts notwithstanding, what matters most to mothers is the chance to be with their babies. It is very rare for a mother to send a baby home voluntarily before the child's first birthday. When this does happen, the motivating factor may not be the baby's best interest. One mother said, "I wanna go to the yard and hang out with my friends." But she was one in two hundred.

Changing patterns of care

When women prisoners first came to Bedford and for years thereafter, they lived across the road from their babies and came to visit them on Tuesdays. The concept of mother-child bonding, though probably known to generations of mothers, was still waiting to be discovered by scientists and disseminated to makers of corrections law. An old picture shows prisoners' babies out under a tree with some mothers, some inmate caregivers, a benevolent looking matron in white, and a large St. Bernard dog. (Sadly, there are no dogs today.) The babies look healthy and happy. There were always plenty of caregivers, even if the special mother-child bond was fostered only on Tuesdays.

From the late 1970s through the mid-1980s, the policy pendulum swung in the opposite direction. Mothers were now up on the nursery floor with their babies, and it was considered very chancy to let one inmate care for another inmate's baby. The age of endless litigation was upon us; a staff person was a legally safer caregiver, though possibly no more competent, than an inmate. It took so long to

clear an inmate to serve as a babysitter in the nursery that by the time she was cleared she might well have been paroled.

Fortunately, the pendulum has swung back to center at Bedford. While an inmate mother now lives with her baby, is its main caregiver, and bonds closely with the baby, she is no longer trapped on the nursery floor for a year. Quite the contrary. After six weeks, earlier if she wishes, a mother is required to go back to school classes if she lacks a high school diploma, to college classes if she qualifies and so chooses, or to some of the few skills classes offered. She also is expected to attend one or more of the self-help programs on drugs, money addiction, and violence, whichever is appropriate to her crime. In this process, the mother begins to learn how to schedule her time to become a working mother outside.

To make all these activities available to mothers, the Parenting Center has opened an Infant Day Care Center in the prison school building. Mothers bring their babies to the center before they go off to classes and other assignments. The Center, which is attractively furnished, replete with rocking chairs and appropriate toys, is staffed by one outside volunteer and five trained inmates.

Funding

Both the Parenting Center, with its many activities, and the nursery are State-funded, with the Center's budget funneled through Catholic Charities and the nursery funded directly. The Parenting Center's initial purpose was to provide for a Children's Center in the prison visiting room and to pay for buses to bring children on monthly visits. The Center still provides these services and also sponsors a summer and Christmas program for visiting children. But as the number of babies in the nursery grows, a larger portion of the Parenting Center budget goes to augment the designated nursery budget. Sr. Elaine Roulet, the Center's founder and director, long ago gave up a full-time secretary in order to hire a nursery manager. Inmates now do much of Sr. Elaine's secretarial work and record keeping. In fact, the wise use of inmate talent and volunteers is a prime secret of the Center's success. It is the only way our extensive children's services could be financially possible in a prison.

The nursery budget allows approximately \$3,000 per year per baby for basic food, clothing, supplies, and furniture. But the budget doesn't include the Day Care Center, some clothing and supplies, the nursery manager's salary, and the occasional cost of getting babies to their outside caregiver. As the needs and work of our nursery become better known, we have received helpful donations of baby clothes from church groups. This much we know: the nursery costs far less per child per year than foster care. The nursery's potential for future social pay-back is something we believe in, but cannot yet reckon quantitatively.

Does it work?

A controlled and comprehensive evaluation of Bedford's nursery has never been made. If it were, plenty of warts

could be found. A follow-up study of the babies themselves has never been made, but it should be undertaken. Finding these children outside would be difficult and measuring what is against what might have been could not be "scientific"—but it could be useful. As it is, our follow-up consists of an occasional phone call or letter with a picture enclosed. We hear about some children when their mothers violate parole and are sent back to prison. Over the long haul, is there less recidivism among our nursery mothers than among other inmates? We don't know. The information must exist somewhere, but time and money would be required to dig it out.

If someone did want to make a study of a prison nursery in the United States, they would have to come to New York State to do it, since New York alone among the fifty states permits incarcerated women to keep their babies with them for the first year. In most states, mother and baby part at the hospital. In a few, in special cases, the baby can come back to prison for a week or two at most, until placement outside is finalized. In view of the vast amount of material now available to us about the importance of mother child bonding, it is difficult to understand why this is so.

"My baby ain't in prison. My baby is with her mama."

In states where prison nurseries once existed, they have been closed. The reasons given for doing so sometimes border on the absurd. During 1980-81 debates in the Florida Assembly concerning the law permitting a woman to keep her baby in prison, the argument most often advanced for repeal of the law was, "A baby born in prison will never smile." The law was repealed. Virgie, a Bedford mother, sounded far wiser when she said, "My baby ain't in prison. My baby is with her mama."

For the most part, babies born to prisoners are babies at risk. Babies at risk are not only tragic—a fact society seems able to live with without too much discomfort—they are also very expensive. And the less care they get early on, the more expensive they become. One might hope that this fact alone would move 49 states to take a new and closer look at babies born to incarcerated women, and then to take action on their behalf based on common sense, common decency, and self-interest. If they do so, prison nurseries will begin to open in other states—unless, of course, our society manages to choose the best solution, and build fewer prisons and more facilities for destitute women and their babies on the outside. ♪

Donations to the Parenting Center can be sent to Sr. Elaine Roulet, 247 Harris Road, Bedford Hills, New York 10507.

A Toddler Experiences Joint Custody: Journal Observations

Suzi Tortora, M.A.A.D.T.R., Private practice, New York City and Cold Spring, New York

Editor's note: When Suzi Tortora called the ZERO TO THREE office, on behalf of a parent in her community, for information about the impact of joint custody arrangements on the development of very young children, we were in the midst of planning this issue of Zero to Three. Recognizing the dearth of detailed observations of young children and families in the early stages of separation and divorce, we invited Ms. Tortora to discuss with the parent with whom she was working the possibility of sharing some of their experience with our readership.

Ms. Tortora's journal entries record her initial meeting with Margret (all names have been changed); her developing and changing relationship with her and her son, Michael; and her observations of Michael from her perspective as a dance movement psychotherapist.

December, 1990

My first meeting with Margret was informal. The local mothers' group was holding a mothers' night out holiday gathering. The event was held in the evening for two reasons—first, to enable moms to come out without their children and second, to encourage working moms to meet other mothers. Margret and I both fit into this second category; we soon realized we had other similarities as well. We both are health care practitioners with an interest in working with families and children. Margret works with the body and movement through physical health and I, as a dance movement psychotherapist, observe and analyze the body and movement as an expression of emotional health. We discovered that our own new babies were both boys, only two months apart in age, and that we had both used the same midwife practice to deliver our babies, she at home and I in the hospital. We planned to introduce her three-month-old son Michael to my one-month-old child the next week. The meeting was fun. We discussed new motherhood, going back to work, the possibility of sharing childcare, nursing, and sleeping habits.

Fall, 1991

The whole winter, spring and summer had gone by, and I had not heard from Margret. Once in the spring we ran into each other in a local store. We both seemed happy to see each other, but we did not make plans to get together. At times I wondered how Margret was juggling her new expanded roles of motherhood, professionalism, and family life. As I was experiencing this balancing of roles myself, I knew it was very consuming, so I assumed we would meet again when possible. Twice in the early fall we tried to set up play dates for our one-year-olds, but it was difficult to coordinate. When we met at the park one of the children always chose that time to nap!

Spring, 1992

The next time I heard from Margret it was early May. One mid-afternoon she telephoned. This time the call was not to arrange a play date but rather for information. Since I was a psychotherapist and worked with very young children and their families, Margret wondered, did I have any information about the effects of divorce on a 20-month-old? She said that she and her husband had recently separated. Their lawyers had come up with a joint custody schedule that was very unsettling to her. Michael was to spend three or four nights a week with his father and some weekends each month as well. The schedule would change daily and weekly, so no set routine could be established. Margret was sure this could not be a healthy program for her young child, but the lawyers said this was a legally acceptable schedule and her motherly concerns had no standing.

I heard crisis and the need for immediate action in her voice. We live in a small community where many women are full-time mothers, and large families who have lived in the area for two and three generations are not uncommon. In such an environment, where could Margret turn for information and support?

Residing in this community for six years now, I have come to realize the need for health care professionals here to make our services more available—blending friendliness and professionalism for families in crisis, especially when children are involved. Immediately I felt myself shift gears from "casual new mother acquaintance" to "resource professional providing sincere care and information."

Although our telephone conversation lasted only fifteen minutes, in that time Margret and I discussed the possibilities of finding a new lawyer who might be more understanding of and assertive about her concerns. We agreed that Michael would have a formal session with me just before the joint custody schedule began and then again six weeks later. We agreed to videotape each session to document Michael's behaviors; this would enable me to write up a thorough movement analysis about his nonverbal expressions. I would look specifically for any significant differences in his behavior between the first and second visit. If needed this report would be used in continued custody negotiations. We agreed that my main role was to use my professional observational skills, acting as a resource, reporter and supporter rather than as a provider of psychotherapeutic intervention with Michael.

Between the time of this conversation and the scheduled appointment, I reviewed literature I had that might be helpful for Margret to read about child development. I referred her to the *Zero to Three* bulletin and the book *Second Chances* (1989) by Judith Wallerstein and Sandra Blakeslee, which I also began to read.

May 6, 1992: Michael, 20 months old

Notes immediately after first session

I am struck today by Michael's gentle, even manner. His often light, soft actions combined with his baby-white hair, sparkling blue eyes, and wide-mouthed smile, left me with a sense that I'd just finished playing with a delicate angel. "Delicate" stands out to me in this description. Although he acted very relaxed, inquisitive and comfortable, freely exploring my room and all the objects in it throughout the hour session, I wonder about this gentle quality. Will it support him to endure all the adjustments and stresses involved in divorce, or will it make him feel more vulnerable? I am eager to review the videotape to get a clearer sense of how this quality is serving him at this time.

Video review

After entering the room and saying hello, Michael casually walks across the room, not immediately focusing on anything in particular but rather looking and wandering. The objects in the room all require physical and often multi-sensory involvement for the child. There is an array of musical instruments, including a rainstick (a long enclosed barrel with beads that ripple from end to end when shaken or rocked), bells, drums, a tambourine, a variety of recorded music, multi-colored sheer scarves, fabric tunnels, a large physioball, a small soft plush ball, books, dolls, multi-ribbed sticks, a large pink parachute, a blanket, and many pillows.

Michael is attracted to the drums. He sits down in front of them visually focusing on them, but not touching. When he does bring his hands up to tap on them he does so with very light sweeping actions. Soon he takes his visual focus off the drums, looking around the room as his hands continue their gentle, consistent beat. In an attempt to draw his full focus back to the drums I tap them, matching his gentle quality but add a bit of quickness to the rhythm. Michael looks, then looks away and does not try my action. Instead he walks away, picking up the plush ball which he draws close to his body, using his hands to tightly squeeze it. He pauses in this position for about 30 seconds and then, looking away, drops the ball and gazes in another direction. During the first 15 minutes of the session he repeated this action with the ball three more times.

Actually, this pattern of engagement and wandering, especially after a more qualitatively intense action such as the one with the ball, was discernible as an overall stylistic pattern throughout this session. Michael's attention span with each object was age-appropriate. However, the personal way in which Michael explored each object and what he did before and after this engagement seem significant. Often when Michael approached an object he would first pause (with varying duration) before he actually became engaged. When he played with the object his handling most often had a gentle, consistent rhythm to it. It is interesting to note that the objects he returned to and played with the most today were the musical instruments. These encourage and enable a wide variety of rhythmic, dynamic expressions.

With each instrument, whether the rainstick, drum, bells, or rhythm sticks, Michael tapped out a very even-tempoed rhythm without any extreme dynamic fluctuations in speed, flow, or muscular intensity. There was a light, almost neutral quality to his rhythm, beginning and ending with a pause. During this pause he would look around the room, at his mother, at me, at the object he was involved with. As he paused and looked around he seemed to be getting an overall sense of his surroundings. He would then proceed with whatever engaged him, or casually wander somewhere else in the room. He appeared very self-directed as he played in this way; neither his mother nor I interfered. Michael only approached us occasionally to get physically engaged in his activities. More often he engaged us through eye contact, seeming content to move about and explore on his own.

Michael seemed to seek contact, visually or physically, especially when he exerted more dynamic strength or intensity than usual. When he tightly squeezed the plush ball he looked at me, paused, and then began to wander. When he hit the rainstick on the floor and then dropped it, he immediately looked at me and then walked away from the scene completely, as if abandoning that type of energetic input. When he became engaged in another activity again he resumed his gentle, more neutral style.

This pattern, repeated numerous times throughout the session, suggested to me that Michael was experimenting with using more strength and assertion but was looking to see our response to these behaviors. Michael's attempt at more assertion, and his quickness in abandoning this quality, stood out as possibly being an expression of how he was trying to process the changing events in his life.

Two points made in Wallerstein and Blakeslee's book (1989, pp. 207, 282) come to mind as I reflect on these nonverbal expressions: consistency and abandonment. Wallerstein and Blakeslee suggest that due to the very young child's complete dependence on adults to meet his physical needs, the fear of abandonment is quite real. Parents coming and going, or the child himself continually transitioning between two locations, can greatly exacerbate the young child's worries about stability, constancy, and the reliability of individuals and surroundings. Whatever consistency is possible in the very young child's life helps the child adjust to all the changes that inevitably accompany separation and divorce.

Michael seems to be experimenting with both consistency and abandonment in his nonverbal movement expressions. Perhaps his even-tempoed, consistent rhythmic phrasing creates a sense of stability. This pattern seems to serve a recuperative function after he has applied a stronger, more dynamic pulse to a play activity, which at this point he abandons soon after he has initiated it.

Based on these stylistic movement observations, my questions at the end of this session are:

- Will Michael develop these subtle tries at being more assertive?

● Is he comfortable applying more direct strength in his interactions, or does he experience these qualities as too threatening or aggressive?

● Is his current preference towards this more gentle, even, observant manner of interacting part of his temperament, or is it a mechanism for coping with the stresses of the divorce?

● Will this style help him to cope in a healthy way?

When Margret reviewed the final draft of this article, she felt it was important to add that Michael witnessed a great deal of anger and physical violence between his parents. The day of the actual separation, the aggression escalated to such a point that Margret had to call the police while Michael's father held him in his arms, captive, refusing to release him.

June 22, 1992: Michael, 21 months old

This session took place after the initial joint custody arrangement had been in place for approximately six weeks.

First thoughts after session:

Michael was very "up" today. He seemed energetic, busy, more outgoing, excited and assertive. His activities were more large motor and physically oriented. He really used the whole space, running as he transitioned between activities, and included running and jumping as activities. Michael did not want to leave after the hour session, whereas last session he asked about finishing after 40-45 minutes. He was animated and bubbly. But at the same time he seemed a bit more easily disturbed. Two or three times during the session he bumped his foot and for a few moments seemed as if he wanted to cry.

This time he squeezed the plush ball with greater intensity and yelled into it. He repeated this action, yelling into the scarves as well. His movements had more strength, directness and quickness to them, and fewer pauses. Michael also wanted his mother and me to participate much more. Often in our play he created a spatial configuration that put him between us, as we would interact within close proximity, forming a line or triangle. It felt very much like the mother-father-child triad to me.

These qualitative additions to his activities made him a delight to play with and added to his sweet disposition. But as I reflect now after the session I note that these behaviors are most likely an expression of his stress. Is he feeling a need to please, or to stay busy and active as a way to not feel? Is his activity a way to get his mother's attention, or is it an expression of all the confusion, abandonment fears and other emotions he may be experiencing more intensely now?

Margret spoke today about adjustment to the joint custody arrangement seeming to be more stressful for her than Michael. She feels very distant from Michael when he first comes back after being with his father. She feels a bit detached and needs some time to adjust and warm up to him again. I question her further about any signs Michael

may be showing of how he is experiencing these transitions. After further reflection, she notes that his nap time is disturbed. He sometimes even misses it completely. There is less routine now. When he first gets home, he asks "Where's Daddy?" His activity level is higher and he races around the house for awhile, as if he is checking that everything is still there. It takes some time to calm him down. These behaviors match what I have seen in session today. I confirm to Margret that these are ways Michael is expressing his needs and concerns. We discuss addressing behaviors that may be triggered by abandonment fears.

I suggest the importance of maintaining his routines as much as possible and reassuring him that he is in his own home with Mommy and all his things. We discuss acknowledging his awareness that their life is changing, now that Daddy lives in a different house. Sometimes he may feel sad, angry or confused and fearful about these changes but both Mommy and Daddy love him very much and will take care of him.

Video review

My analysis of the video of this session further substantiates my initial observations. Michael's heightened activity level and increased use of strength manifested not only a more determined, effortful sense of assertion, but even enabled some expression of aggression. It is significant to note, though, that even his more aggressive acts were performed within his even-tempoed manner. For example, Michael asked us to help him lay a large Raggedy Ann doll on the floor. He then proceeded to step repeatedly on her face, but with a contained, diminished use of strength without any bursts or fluctuations in exertion or timing. As in the past when he's been more assertive, he looked up at me and then his mother. But this time he went over to his mother, and she then joined him in stamping on the doll's face. In contrast to the last session, this time his pauses and looks at us functioned as a way to ask us to actively join him in his more assertive actions. By approaching us he nonverbally directed us to engage with assertion, rather than abandoning the actions as he had done in the previous session.

Adding more effort to his movements heightened the results. This week he ran to the large ball and pushed it with more strength and a quicker pulse, causing it to roll more freely and quickly away from him. The second time Michael pushed the ball he kept up with it, running behind the ball rather than watching it roll away. Such actions encouraged him to continue to expand his expressive movement repertoire. When Michael picked up the rainstick a few minutes later, he held it still at first, and then, with a small action, began tapping it on the floor. When he soon added more strength, causing a louder sound, he stopped and exclaimed with glee "ahhh!" as he opened his mouth wide. He looked at Mom and then repeated the action and vocalizing again. Michael developed this activity further by bringing the rainstick to his mother and had them bang it on the floor together. He then tugged it away from her, gave it a push and let it drop to the floor with a bang.

Throwing and releasing playthings so they dropped was more evident today.

As Michael left, I wondered how these behaviors might develop during the week. It felt as if he was beginning to let some of his more difficult emotions become expressed through his actions.

June 27, 1992: Telephone conversation with Margret

Margret told me that on Monday afternoon, some hours after our session, she and Michael had been talking about his day. He recalled playing and seeing himself on the videotape and excitedly said he would like to come back to play with me again.

The rest of this week had been difficult. Margret reviewed Michael's schedule. Michael had spent the weekend with his father and was dropped off at Margret's Sunday evening. He had missed his nap that day so he ended up sleeping 13 hours (usually he sleeps 11 hours) that night. Monday morning he had a session with me, then was dropped off at daycare; Margret went to work. Monday night he went back home to his father's, returning to Margret's on Wednesday evening. Thursday morning Margret was very tense, for she had a joint meeting with her lawyer, her husband and his lawyer. The agenda was to modify the current joint custody arrangement. Michael woke up early this Thursday morning. He would not eat, get dressed, or cooperate in any way. He was running all around the house very "wildly." Margret felt his assertiveness of Monday had become obnoxious and out of control by Thursday. He maintained this behavior all day with the babysitter (at his home). He would not nap or eat lunch and didn't get to sleep until 11 p.m. that night. Finally, through the course of the whole weekend, he calmed down.

Margret couldn't be specific about what actually worked to settle him. She said she just "rode it through with him," trying to stay attentive and supportive of his expressions. She was very concerned. Again we spoke about acknowledging his feelings of anger, sadness, frustration and fear.

Margret did have good news to report as well. Her new (third) lawyer had been successful in modifying the custody schedule. Michael would spend three weekends per month with his father. One weekend a month and all week he would be with Margret. Each parent would spend a two-week summer vacation with Michael. Margret felt this female lawyer was tougher, more assertive, and more direct than her previous counsel. The attorney told them that she had two young children herself and knew that the previous custody arrangement was just too disruptive for a young child. It was unacceptable. This time Margret's husband and his lawyer listened and agreed without an argument. We hoped this new schedule, which would allow for more regularity and routine, might help Michael's adjustment.

July 3, 1992: Michael, age 22 months

I saw Michael informally at a local library play group. He ran up to me and gave me a hug. He seemed very happy

to see me. He was carrying his bottle. Margret said it has become a very important object for him. He asks for it frequently and needs to know it is with them. Although she has some concern about how long he will continue to want a bottle, she is aware of its role as a consistent, comforting object. She is not interfering with his need for it at this time.

August 21, 1992: Michael, age 23 months

I met Michael and Margret at the park. Michael seemed very happy, jovial, and relaxed. Michael had just spent eight days on vacation in Colorado with his father, followed by a week's vacation with his mother. Margret felt that Michael seemed to benefit greatly from spending a vacation with each parent. Having each parent's sole attention, without their having to go to work, helped Michael to relax fully and seemed to strengthen the separate relationships he is now developing with each of them. With his budding vocabulary he excitedly told me about his plane trip. My son had fallen asleep in the car so I told Michael we would join them in the park when he woke up. Michael and his mother began to walk away but then returned. Margret said Michael wanted to see my son sleeping. She commented that lately he doesn't want anyone to go away once he has made contact with them. "He has become very sociable and friendly, unlike his parents who are more shy," she said, "He seems to quickly make attachments to people." This again was evident when I was about to leave the park. As I approached the gate, Michael ran up to me with a big smile. I did not feel that he was clinging to me but rather that he enjoyed my company and wanted to continue the contact. We confirmed for him that we were all going to have lunch together, he seemed pleased, and we all left the park.

During the rest of the time we spent together, Michael maintained his calm, joyful attitude. He acted confident and interested in the surroundings and the other children present. He was able to sit at an outdoor cafe table alone, while Margret went inside the restaurant. He seemed patient and content to sit quietly and wait for all of us to come out. He watched my son run down the street and eagerly followed him, even holding his hand as they continued. He freely wandered away from his mother, letting her talk to the other adults present.

As I reflect on Michael's behavior after our visit, two points from the Wallerstein and Blakeslee book come to mind. First, the children of divorce in their study often became very aware of others' comings and goings. Michael's behavior matches this pattern. He seems to be looking for constancy and reliability with people who enter his life, even if it is just for the afternoon. The second point concerns temperament. Wallerstein and Blakeslee note that a child's basic temperament plays a major role in how well he or she will adjust to all the changes surrounding divorce. They cite flexibility and a relative calmness and easygoing quality as key strengths that will facilitate a smoother adjustment to the changing circumstances caused by divorce (p.269).

Michael's calm, gentle qualities certainly seem to be enabling him to maintain a level of control as well as flexibility.

August 31, 1992: Michael, age 23.5 months

My child and I met Michael and Margret at the swimming pool. Again, Michael's calm and friendly disposition were evident. His even-tempered, observant manner enabled him to transition easily from clothes into bathing suit; into the warm water; playing with and without mom; and then back out into the cool, late summer air. As he and my child played, Margret and I spoke about her feelings of loneliness and the loss of a family life. The relationship between Margret and her husband has calmed down considerably. Without the distraction of the turbulence in the relationship, she can now begin to feel sadness. A new life is beginning to take form. Margret and her husband are both becoming more cooperative and effective in their separate co-parenting roles. Michael's schedule has become more consistent and reliable.

Reviewing this section, Margret attributed these changes to the support couples' therapy has provided for herself and Michael's father. She felt that the power struggles and adversarial stance embedded in the attitudes of the lawyers and the legal system greatly contributed to their struggles in relating. It is through therapy, which they began during this month, that they began to learn how to express themselves, listen to each other, and negotiate more clearly and effectively.

September 6, 1992: Michael, age 24 months

When my son and I attended Michael's second birthday party, I had my first opportunity to watch Michael with his father. Michael's father arrived about 1½ hours after the party began. Up to this time Michael had been very much himself and did not appear anxious about his father's absence. When his father did come, Michael seemed happy to see him but was eager to resume his play with the other children after they hugged hello. Only when everyone at the party went for a walk did Michael get upset, when he thought his father was not coming also. During the walk he spent most of the time with his father.

Michael's pausing, less actively assertive quality was especially apparent in contrast to the behavior of other children at the party. At times this observing quality seemed to suspend him in time and space. At one point all the children were climbing up and down a slide. Michael waited nearby, but did not make it clear that he was "in line." Older and younger children climbed up and down the slide, racing around him with fast, darting actions as he stood still, seeming to watch, but not actively deciding to participate. Adults nearby began to encourage him to take his turn. One adult then physically helped him to climb up the slide while he instructed the other children to wait their turn. It did not appear to me that Michael was incapable of climbing up the slide; rather, he seemed to prefer not to participate in the excited, boisterous manner that the

other children were demonstrating. When the other children were helped to wait and give Michael his turn, he took his time and in his gentle, calmly gleeful way went down the slide with a bright smile. This slow, pausing movement quality seemed to cut through the heightened excitement of the room. It also enabled him to attract the attention of an adult, who then helped adjust the environment so he could take his turn his way.

Michael's father especially seemed to assume the role of "Michael's helper." Throughout the party, the father came to his son's side and helped negotiate for him. At one point, for example, a child was playing with Michael's toy hammer. When Michael tried to take it, the child sat on it. Michael watched as his father came over and said, "It is Michael's party. He should have his toy back." When the child still did not return the hammer, the child's mother took it from him, and gave it to Michael. During this encounter Michael sat patiently and watched.

Again the notion of temperament flashed through my mind. Without causing a disturbance but, rather, by altering the climate of the room, Michael was able to get the support and attention he needed. Wallerstein and Blakeslee (p. 267) note that, overall, children of divorce do turn to adults for help. Although this pattern can be seen as increased dependence than is common among children in two-parent families, it can also be viewed as evidence of children's trust that assistance from an adult is available.

For Michael, assistance from adults currently seems to be facilitating his coping with the changes going on in his life. It will be important to watch how this develops. Specifically, we will want to see if Michael can internalize the helpfulness of adults so that he becomes able to maintain clarity and strength through his own life struggles, or if he will become dependent on the need for others to clear the path for him.

October, 1992: Reflections

As Margret and Michael seem on their way with this new life style, I find my role shifting back again to that of a friendly mother with a child close in age to Michael, and less of a clinical observer. I find myself reflecting once more on an observation of Wallerstein and Blakeslee:

One cannot predict long term effects of divorce on children from how they react at the onset ... As the years went by, we discovered that themes and patterns shifted with each developmental stage. A color that showed little at the onset might later come to dominate the design (p. 15).

References:

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Infants, Toddlers, and SSI: Changing the Rules, Reaching the Children

Rhoda Schulzinger, Director, Children's SSI Campaign, Mental Health Law Project, Washington, D.C.

Brian Zebley was born in 1978 with congenital brain damage, eye problems, partial paralysis and various musculoskeletal abnormalities. Brian's family applied to the Social Security Administration (SSA) for Supplemental Security Income (SSI) benefits. SSI is a federal cash assistance program for financially eligible children with disabilities or chronic illness. In most states, children who receive SSI are automatically eligible for free health care through Medicaid. At the time that Brian Zebley applied, however, a child could qualify for SSI benefits only by "meeting or equalling" a specific condition on Social Security's list of childhood disabilities. The list had not been updated since the SSI program began in 1974. Many childhood conditions, such as autism and Down Syndrome, were not included on the list. Social Security said that Brian was not disabled under the federal regulations and denied his application for SSI.

A lawsuit was filed on behalf of Brian and other children across the country to challenge the strict childhood disability rules used by Social Security. The case, called *Sullivan v. Zebley*, went to the U.S. Supreme Court, which ruled in February, 1990 that Social Security's childhood disability rules violated Social Security's own statute by failing to provide for children the individualized assessments that were available to adult applicants. The Supreme Court ordered the agency to change its disability determination procedures for children. The Court also ordered the agency to re-evaluate any of the 452,000 children who had been denied benefits for medical reasons after January 1, 1980 who requested a review under the new rules. These children (some of whom are now adults) may be eligible for SSI benefits back to the date they first applied.

Access for children to SSI benefits expanded greatly a second time in 1990 when, in December, the Social Security Administration issued updated and improved regulations for evaluating children with mental and emotional disabilities. The revisions, the result of six years of discussion among Social Security staff, child development experts, and advocates, are extremely important because nearly half the children receiving SSI have some type of mental or emotional disability.

In February, 1991 Social Security issued regulations for a new process of evaluating disability in children that reflects a more expansive philosophy. Now it is possible to go beyond the specific requirements of SSA's "listing of impairments," and also examine a child's ability to attain developmental milestones and perform "age-appropriate activities." The disability evaluation process now considers how the child's condition interferes with his or her ability to do the kinds of everyday things a typically developing child of the same age can do. The functional approach is a positive move away from a strict diagnosis-driven concept of disability.

The new rules also include special provisions for newborns and infants. This change is especially important because Social Security used to defer eligibility decisions about infants until they could be tested or had a measurable IQ. Under the new rules, premature infants and those with certain life-threatening conditions can now qualify for benefits in far greater numbers.

The *Zebley* decision and the new regulations offer a major public awareness challenge to the field. With the combined efforts of advocates and families, the number of children receiving SSI benefits has increased in the six months following December, 1991 from 438,853 to 519,380, an increase of 18.3 percent. However, more than half of all children with disabilities in low-income families who should get SSI benefits still do not receive them.

Practitioners who work with infants, toddlers, and their families are uniquely well placed to identify children who are potentially eligible for benefits, to assist families in the application process, and to provide documentation. This article provides a step-by-step guide to the process of establishing infants' and toddlers' eligibility for SSI, as well as an introduction to the Children's SSI Campaign, a national outreach effort to enroll eligible children of all ages in the program.

Establishing financial eligibility

Children who meet both blindness or disability standards and financial requirements are eligible for monthly cash benefits under SSI. In 1993, the maximum federal benefit will be \$434 per month. About half the states supplement the federal benefit. In most states, children who receive SSI are automatically eligible for free health care through Medicaid.

SSI financial eligibility requirements are more liberal than those for Medicaid in most states. Eligibility is calculated every month, so families who are found not eligible for financial reasons should reapply if their income drops.

To apply for SSI, a family must call or visit a Social Security office. All local offices have public telephone numbers listed in the telephone book or with directory assistance. Social Security also has a national toll-free number, 1-800-772-1213, open 7 am-7 pm Eastern time, Monday through Friday. The best times to call are early or late in the day because the line is often busy. Social Security will schedule an application interview at the local office or make an appointment for a telephone interview.

A potentially eligible family should schedule an application interview as soon as possible because benefits are paid from the date of the initial visit or phone call. Families should not wait until they have all the necessary medical and non-medical documentation about their child's condition. This information can be submitted later although it should be collected as early as possible in the process.

The Social Security claims representative collects information about the family's finances. If the family meets the financial requirements, Social Security sends the case to the state Disability Determination Service.

Establishing disability eligibility

Only children who are financially eligible for SSI have their cases reviewed by a disability examiner. This examiner must get information about the child's condition from people who regularly treat or observe the child. The disability examiner never sees the child, but reviews all the information and, with a medical or psychiatric professional, decides if the child meets the disability requirements. To meet the disability rules, the child's physical or mental impairment(s) must limit his or her ability to develop or function in an age-appropriate manner.

A child can establish disability in one of three ways:

1. A child can have a specific medical condition on Social Security's "Listing of Impairments."
2. If the child's condition is not listed, evaluation can show that the disability or combination of disabilities is "medically or functionally equivalent" in severity to a listed condition.
3. If the child's impairment does not "meet or equal" a listed impairment, the disability examiner must complete an individualized functional assessment to determine if the impact of the impairment(s) substantially reduces the child's ability to develop or function in an age-appropriate manner.

Social Security established standards of age-appropriate developmental milestones and activities for each of six age groups. For young children, the age categories are: newborns and young infants (birth-age 1) and older infants and toddlers (1-3). Older children are grouped as preschool (3-6), school-age (6-12), young adolescents (12-16) and older adolescents (16-18). This article will only discuss the how the process affects children under age three.

The sequential evaluation of a child's disability

Social Security regulations govern the evaluation of the severity of a child's impairment(s) and how the impairment interferes with the child's ability to develop or function. For a child under three to qualify for SSI, his or her impairment must "substantially reduce" the ability to attain developmental milestones at an age-appropriate rate.

Step 1: Meeting a listing

Social Security's "Listing of Impairments" has 66 physical and mental conditions that can establish SSI eligibility. Examples of listed conditions include cystic fibrosis, sickle cell anemia, cerebral palsy, and attention deficit hyperactivity disorder. A child with one of these conditions must meet very specific requirements to qualify. For example, a child with sickle cell anemia must experience a certain number of episodes of illness within a specific time period. They must be documented by description of severity, frequency, and duration.

There is a new, separate listing for Down Syndrome. Other serious hereditary, congenital or acquired disorders

affecting more than one body system have recently been added to the list of impairments. Conditions now covered more explicitly include fetal alcohol syndrome, phenylketonuria (PKU), severe chronic neonatal infections, and prenatal drug exposure. Although Social Security has guidelines to evaluate children who are HIV positive, they have not been published in final form.

The new listing for newborns and young infants (ages 0-1) has five criteria. Meeting one criterion is sufficient for the child to qualify for benefits. Four criteria correspond to domains of development: cognition or communication, motor skills, social interaction, and responsiveness to stimuli. Children with an "extreme" limitation in any one of these domains meet the listing.

An infant without extreme limitations will be evaluated under the fifth set of criteria, which qualifies a child with a "marked" limitation in two of three domains: motor skills, cognition/communication or social interaction. Social Security defines "marked" limitation as functioning at a level generally acquired by children who are no more than two-thirds the child's chronological age. This must be documented by appropriate medical findings and, if possible, standardized testing.

Infants and young children also benefit from changes in the listings for childhood mental disabilities that now allow children to be evaluated on the basis of both clinical findings and age-specific functional limitations.

Step 2: Medical or functional equivalence

Even if a child's condition is not found on Social Security's Listing of Impairments, the effects of the condition on the child can be either medically or functionally equivalent in severity to a listing.

Examples of conditions that Social Security considers functionally equivalent to a listing appear in the regulations. Several affect young children:

- need for a major organ transplant;
- birthweight of less than 1,200 grams (about 2 pounds 10 ounces);
- birthweight of at least 1,200 grams but less than 2,000 grams if the newborn is determined to be small for gestational age;
- in an infant under age one, any physical disorder (or combination of physical and mental disorder) that satisfies the requirements of the special listing, "Developmental and Emotional Disorders of Newborns and Infants";
- major congenital organ dysfunction that could be expected to result in death within the first year of life without surgical correction, until age one; and
- tracheostomy or gastrostomy in a child under age three.

The list of functional equivalence examples in the regulations is not all-inclusive. The consequences of each child's impairments must be individually assessed by the disability examiner.

Step 3: Individualized Functional Assessment (IFA)

If a child's disability does not "meet or equal" a listing, SSA will perform an individualized assessment of the child's ability to reach developmental milestones or do the everyday things other children of the same age can do. The assessment is a review of all the relevant documentation of the child's disability—it is not an actual physical examination of the child. The disability examiner never sees the child.

To determine eligibility, the disability examiner looks at age-specific behaviors and domains of development and functioning. Developmental domains are evaluated for children under six. (For older children, the functional domains are assessed). For children under age three, the five domains and behaviors evaluated are:

- cognition;
- communication;
- motor skills;
- social abilities; and
- responsiveness to stimuli (under one year) or personal and behavioral patterns (over one year).

For children under age three, functional limitations may be rated in terms of developmental delay or a fraction of the child's chronological age.

Under the new regulations, Social Security must for the first time consider impairment-related factors that may affect a child's development and daily functioning. Examples include chronic illness, side effects of medication, hospitalizations, effects of structured or highly supportive settings, and need for intensive therapy.

There are specific guidelines for an individual functional assessment of premature and low-birthweight infants.

How can infant/family practitioners help?

Many professionals and community advocates who work with infants, toddlers, and their families do not know that eligible lower-income children with disabilities can receive a monthly cash payment through the SSI program. The program is not widely publicized, and under the pre-Zebley disability rules, hundreds of thousands of children who did apply for benefits were turned down. The word on the street was "Don't encourage families to apply for SSI benefits." Infant/family practitioners now have a chance to work with the Children's SSI Campaign, a national outreach effort to enroll more children.

Professionals and other caregivers who work with a potentially eligible child can help document the child's disability. Children who apply for SSI need to provide extensive documentation about their condition to the disability examiner. Both medical and non-medical information can be used to support a child's application for benefits. Records of all past or present medical problems, even if they seem unrelated, will bolster a child's application. It is also very helpful to include very specific reports from parents and other caregivers describing examples of how the child is not developing or performing age-appropriate daily activities. Statements from physicians, psychologists, nurses, therapists

and aides, teachers, school counselors, workers at developmental centers and preschools, early intervention specialists, social workers, clergy, relatives, neighbors, friends and the parents or any regular caregivers are all critically important.

SSI cash benefits are designed to help low-income families with the extra expenses associated with caring for a child with a disability or chronic illness. It is important to recognize that the SSI application process does focus attention on the child's limitations rather than strengths. Consequently, the application must show the extent to which a child's condition interferes with his or her ability to do the everyday things that typically developing children of the same age can do. When practitioners and families have worked closely together to identify and build on the strengths of an infant or toddler, shifting focus to document disability, in great detail, is no easy task. Staff and participating parents in infant/family programs may find it helpful to discuss the new SSI regulations and develop together some general guidelines for informing parents about benefits and working with those families who choose to apply. It will also be important to be sensitive to each individual family's experience of the application process.

Infant/family practitioners can help the family gather the necessary medical records and non-medical reports that document the child's disability. A trained family advocate or professional can expedite the application process by contacting different sources and urging them to provide the necessary reports promptly. If the family consents in writing, an infant/family practitioner may give his or her name and telephone number to the disability examiner. This is very useful if the examiner needs additional information and cannot reach the family by telephone during the day.

Infant/family practitioners and advocates can also help track the progress of a child's application.

- Thirty days after the child files for SSI, a family member or someone working with the child should call the local Social Security office to check on the status of the case. Ask if the child is **financially eligible**. If so, the case should have been sent to the disability examiner at the state agency.
- A second call should be made to the disability examiner to check whether all the medical and non-medical sources suggested by the family were contacted. The disability examiner can be reached by calling the Disability Determination Services—ask Social Security for the telephone number. (There is a toll-free number in many states.) Give the child's name and Social Security number and you will be told which examiner has been assigned. This call is very important because the disability examiner has dozens of cases and may overlook important information about one case.
- Find out what information or records are missing and call those sources so that the case can be processed with the benefit of complete and accurate information about the child's condition.

The Children's SSI Campaign

The Children's SSI Campaign is a national outreach effort to let families and service providers across the country know that new SSI eligibility rules allow more children to qualify than ever before. It is especially important to find the 452,000 children who applied for SSI between 1980 and 1990 and were denied for medical reasons.

The Campaign involves a wide range of people—social services workers, health providers, educators, community activists, unions, children's advocates and membership organizations. In some states, local organizations are coordinating statewide campaigns with technical assistance and materials provided by the national campaign staff. Action Kits are available free of charge from the Children's SSI Campaign. The kits explain the SSI program and application process and suggest outreach activities to help find eligible children. Write to the Children's SSI Campaign, 1101 Fifteenth Street NW, Suite 1212, Washington, DC 20005.

To discuss possible participation in the national campaign and outreach activities in your state, call Rhoda Schulzinger, Director of the Children's SSI Campaign at the Mental Health Law Project, tel: 202/467-5730. ♣

The Children in the Zebley Lawsuit

Beginning in July 1991, the Social Security Administration began mailing several notices to all the children (some of whom are now adults) who are part of the Zebley lawsuit. If you know a child who applied for SSI between 1980 and 1990 and who was turned down for medical reasons, ask if the family received a notice from Social Security about the case. If the family did not receive or answer the notice, immediately send the child or family to the local Social Security office to request a Zebley review. If the child is not now receiving SSI, he or she should both file a new application and request a Zebley review for back benefits. Parents of children who have died in the interim may also apply for the benefits their child would have received.

Families who want more information about the lawsuit should call the Zebley Hotline at 800-523-0000 from 9-4 Eastern time, Monday through Friday. The family can speak with someone who is working with the attorneys who represented Brian Zebley. The hotline staff can answer questions about who is eligible, how to apply for back benefits and how to use this money without jeopardizing a child's current SSI payment. Service providers and child development specialists are asked to call the attorneys at their regular telephone number, 215-893-5300.

Head Start: The Next Generation

Edward Zigler and Susan Muennichow. Excerpted from Head Start: The Inside Story of America's Most Successful Educational Experiment (New York: Basic Books, 1992)

"Why did Head Start succeed?" a reporter asked me recently. "And why did the rest of the War on Poverty fail?"

Unlike many social critics, I do not think the War on Poverty failed, but rather that it was prematurely halted. The one campaign in that war that was allowed to continue, namely Head Start, has been a success. Head Start is far from perfect, and the reality has often not measured up to the possibility. But there was something about Head Start that was able to bring together diverse people for the sake of the children, and, more than 25 years later, it still has the capacity to inspire people as far apart politically as Jesse Jackson and Orrin Hatch.

High hopes made Head Start possible. Some of the hopes of the mid-1960s were naive; some led to inflated promises that no social program could possibly deliver. But we need to recapture the hope, to believe once more that it is possible to set the next generation of American children and families on a course toward a better life.

It is time for Head Start to build on its status as the nation's laboratory for services for poor children from birth to age 5. Head Start, the birthplace of comprehensive services in a family setting, should be the first place to experiment with quality programs for infants and toddlers, therapeutic

services for drug-exposed children, and improvements on its own two-generational strategy for fighting poverty.

During the 1970s, Head Start did serve as a national laboratory, taking the lead on such efforts as Home Start, competency-based training in the form of the Child Development Associate program, and family support programs, such as the Child and Family Resource Program. Head Start also had the research, demonstration, and evaluation (RDE) budget to support these efforts. In fact, it might be said that we focused on these experimental programs almost to the exclusion of the expansion of the basic center-based program for preschool children.

The election of President Reagan, however, brought Head Start's national laboratory to a halt. Research, demonstration, and evaluation declined from 2.5 percent of the overall budget in 1974 to only .11 percent of the total budget in 1989. Fortunately, under the Bush administration, research funds were almost back to their 1971 level of \$4 million by 1991, and scheduled to rise to \$7 million in 1992. Head Start is also once again promoting innovations, such as its new Substance Abuse Initiative, which attempts to provide guidance to grantees on how to work with children and families affected by drug or alcohol abuse.

Amid the calls for "full funding" for Head Start in the 1990s, therefore, Head Start now stands at a crossroads. How can the program expand to serve all the children and

families who need it and, at the same time, renew its status as the pioneer and innovator in child and family programs?

We have five major recommendations, which build upon those recently offered by the Silver Ribbon Panel of the National Head Start Association. These include: providing "full quality" Head Start; recognizing Head Start as a full partner in welfare reform; revamping Chapter 1 to sustain Head Start benefits in elementary school; and raising the income eligibility guidelines. (For a fuller discussion of these recommendations, see *Head Start: The Inside Story, America's Most Successful Education Experiment*.) We also recommend that Head Start be allowed to serve infants and toddlers.

Almost from the outset of Head Start, there has been concern that the program started too late. Head Start's founders knew that a six-week or even one-year program directed at three- and four-year-olds could not inoculate a child against poverty. We started with that age group primarily because there was still widespread prejudice against any out-of-home program for infants, and because there was very little experience with programs for children below preschool age.

Soon after the initiation of Head Start, the Johnson administration created 36 new Parent and Child Centers to serve children from birth to age three. During the 1970s the Office of Child Development initiated a demonstration project called the Child and Family Resource Program, which offered comprehensive services to children from birth through age eight. The 1980 report on Head Start requested by President Carter noted that "it makes no sense to wait until a child is age three to make sure he or she has the proper nutrition.

What was true in 1970 and 1980 is even more true today. First, Head Start is working with more dysfunctional families than it was in previous years. In a nation where infant and toddler deaths from totally preventable diseases are increasing, children need an earlier "head start" to ensure their very survival. When families are afflicted by substance abuse, domestic violence, or child abuse, child victims literally may not be around to benefit from a Head Start program that does not begin until age three or four. Infant and toddlers of teenage parents, in particular, could benefit from Head Start services.

Second, Head Start must adjust to a society where the entrance of parents with young children into the workforce is the norm, and where welfare policies mandate that parents of children age three or over either work or enroll in training. Head Start's parent involvement component, in the sense of actively involving parents as classroom volunteers or as recipients of home visits, simply does not work as well when parents are expected to be employed full-time. In order to maintain this excellent component of Head Start, the program must reach out to parents of younger children who are more apt to have time to volunteer in the program and who may gain more from home visits because their patterns of parenting are just forming.

Thus, we support the Silver Ribbon Panel's recommendation that by the year 2000, Head Start should build the capacity to serve children under age three. Our specific recommendations include the following:

Give communities the flexibility to spend expansion dollars on infants and toddlers

Lest we be accused of expanding the target population for Head Start before the program has served all the eligible preschool population, we think it is important to point out that statistics indicating that Head Start services a third* of the eligible population can be misleading.

These statistics do not take into account the other programs serving poor preschool children. Much has changed since 1965, when Head Start was the only preschool program in many communities. Thirty-five states now offer some kind of prekindergarten program targeted at disadvantaged four-year-olds, and a substantial portion of subsidized child care funds in many states also goes to the preschool age group. Summing up the status of publicly funded early childhood programs, Joan Lombardi, project director for the Silver Ribbon Panel, notes, "It has gotten to the point that if you are poor in this country, your children better be four years old, since that is when they will finally have priority for services."

No doubt fully aware that a large number of eligible four-year-olds are already served in other programs, the Bush administration focused on four-year-olds as the target group for Head Start. Politicians like to narrow the size of a target group precisely so they can boast that they have served all of the "eligible" population.

Head Start advocates have been reluctant to address how many of the eligible four-year-olds are already served in other early childhood programs for fear of limiting funds

SUBJECTS AND PREDICATES



*The Congressional Research Service estimates that the program serves 28 percent of the eligible children. Other estimates range from one-fifth to one-third.

for expansion. Yet, Head Start need not have a monopoly on services for preschool children in order to make the case for new funding. It is time to identify systematically how many of the eligible four-year-olds are already served in other programs that have the potential to provide comprehensive services, precisely so that Head Start can be free to serve younger children.

What we are recommending is that each Head Start grantee, with the consent of its Policy Council, be allowed to decide how to spend its own expansion dollars. In those communities where there are already other programs serving a large portion of the four-year-olds, Head Start programs may prefer to target expansion dollars to infants and toddlers, particularly children of teen parents and those who are drug-exposed. Head Start programs should have the flexibility, based on a community needs assessment, to make their own decisions on which age groups to serve. Indeed without this flexibility, it is questionable why Head Start programs should bother to conduct community needs assessments at all.

Allow Head Start more discretion in program options

Closely related to the above recommendations is that Head Start be allowed more discretion in program options. During the 1970s, Head Start experimented with the Child and Family Resource Program (CFRP) model, which offered a broad range of services to children from birth through age eight. Far from being limited to a classroom-based program the CFRP offered such services as home visiting for infants, special services for developmentally delayed children, and even therapeutic services, such as crisis intervention and counseling, on an "as-needed" basis.

Unfortunately, despite favorable evaluations of the CFRP by both Abt Associates and the General Accounting Office, the Reagan administration terminated the CFRP program in 1983. The Reagan stance seemed to be to keep Head Start alive, but dispense with what he regarded as "frills." Under the Bush administration, some of the old spirit of innovation in Head Start was restored. With passage of legislation enacting the Comprehensive Child Development Centers in 1988, some demonstration funding was provided to establish multiservice centers for children from birth to age five. ACYF Commissioner Wade Horn has also established some Family Service Centers, which embody certain aspects of the CFRP programs.

However, what is still missing is the conception that the CFRP cafeteria model, offering families a range of service options, should be incorporated into the very essence of Head Start. Particularly with respect to services to children under age three, it is likely that not every family would want center-based services. For this age group, Head Start might want to emphasize its health, social service, and parent involvement components. Given the fact that children under the age of two have the lowest rates of immunization, just making sure that infants get inoculations would be a major service. In addition, Head Start might want to offer therapeutic services, more intensive but fewer hours per week, to families with drug-exposed infants and toddlers.

Implement the infant and toddler performance standards

A major barrier to the expansion of Head Start services to younger children has been the failure to promulgate performance standards specific to this group. As **ZERO TO THREE**/National Center for Clinical Infant Programs has noted, "the care of infants and toddlers must be regarded as a distinct kind of care, not as a scaled down version of the care of older children." Without specific standards for infant care, even the commitment by Congress to ensure that every state has at least one Parent and Child Center serving infants and toddlers may achieve far less than it could.

Parent and Child Centers have been operating for more than two decades without any federal standards, thereby placing the most vulnerable age group of children at risk. ACYF has been struggling to agree upon and implement standards for at least five years. In 1986 the agency completed a first draft of the standards, and in 1990 it finally released proposed infant and toddler standards for public comment in the Federal Register. Congress stated its intent in the last Head Start reauthorization act that the standards be implemented in a timely manner. Nevertheless, as of this writing, they have yet to be finalized and enacted.

The proposed rules would require that teachers in Parent and Child Centers have a CDA (Child Development Associate) credential in the infant and toddler area or other certification in child development, and would also set standards for health screenings for infants. **ZERO TO THREE** has suggested some revisions in the proposed rules, such as easing up on the requirement that parents agree to spend half the program time at a Parent and Child Center in supervised parent-child interactions. **ZERO TO THREE** and other groups also consider the proposed one-to-five staff-child ratio insufficiently protective for infants as young as 13 months.

We recommend that ACYF incorporate the **ZERO TO THREE** suggestions and finalize the Infant and Toddler Performance Standards immediately so that Head Start can proceed with the expansion of quality services for this vulnerable age group.

In sum . . .

Head Start is the nation's most successful educational and social experiment. It was a pioneer in providing comprehensive services in a family-centered context, and it continues to offer the only real two-generational assault on poverty. Over 11 million children are better off today because of Head Start—in some cases, dramatically better off. Yes, Head Start can be—and should be—improved. But our commitment to an ever-improving Head Start is based on the record of its services to children and families so far. Head Start has proved itself as the nation's laboratory for child and family programs that is most deserving of our support. §

ZERO TO THREE Notes

by Eleanor S. Szanton

It's transition time. In Washington, D.C., in state capitols, and in local jurisdictions all over the country, newly elected officials are selecting staffs, consulting advisors, and preparing to face the tough challenges and choices ahead. All of us who care about—and know about—infants, toddlers, and their families should become a part of this process.

We talk about ZERO TO THREE/National Center for Clinical Infant Programs as a partnership. That partnership must include policymakers. Over the years ZERO TO THREE has worked hard to build and maintain a reputation among policymakers as a source of reliable information and, perhaps even more important, as a link to the daily experience of a broad range of young children, families, and practitioners. ZERO TO THREE Board members and staff will continue efforts to educate policymakers at all levels of government, but we can be more effective working in partnership with people who are not only experts, but constituents as well.

Here are some ideas for working together to inform policymakers on an ongoing basis about issues that affect infants, toddlers, and their families. We would welcome additional ideas.

The Heart Start/Zero to Three Double Whammy: As many of you know, ZERO TO THREE's new publication, *Heart Start: The Emotional Foundations of School Readiness*, is designed to engage policymakers who are concerned about education, the economy, and the labor force, but who may never previously have thought about infant and toddler development or made a connection between the well-being of infants, toddlers, and their families and the well-being of the economy. *Heart Start* offers recommendations, appropriate to federal, state, local, and corporate initiative, to address the needs of all young children for health, unhurried time with caring adults, responsive caregiving, and safe environments.

When you purchase a copy of *Heart Start* for \$13 to send—with a personal letter from you—to a federal, state, or local policymaker, ZERO TO THREE will send that policymaker 6 issues of *Zero to Three* at no additional cost. You can let us know whether the subscription should be

sent to the official's Washington or state capitol address, or to his or her district office. Your letter will let each policymaker on your list know your own areas of special interest and expertise, and how you can be reached for information and advice.

The Extra-strength Information Package: To give a policymaker new to infant/family issues a selection of good information more detailed than *Heart Start*, you can send her or him a package that includes, in addition to *Heart Start: Maternal Health and Infant Survival* by C. Arden Miller, M.D.; *Preventive Health Care for Young Children* by Bret C. Williams, M.D., MPH and C. Arden Miller; the June, 1991 issue of *Zero to Three* on environmental hazards to young children's development; and the August/September, 1992 issue, on infants and toddlers exposed to drugs, alcohol, and tobacco. We will make the information package available at the special price of \$28, shipped to you so that you can include your own letter and call the policymaker's attention to specific points or articles of special relevance.

The Personalized Briefing Book: As long-term readers of *Zero to Three* or browsers through its cumulative index know, we have published articles on a wide range of social issues that affect infants, toddlers, and their families—child care, child abuse prevention and treatment, home visiting, infants and toddlers with special needs, family leave, cultural diversity, prematurity and low birthweight, and program effectiveness are some examples. In addition, we have published separate reports and pamphlets on a range of issues. If you know the specific infant/family issue or issues that concern an individual policymaker—or if you are looking for materials that will enhance your own effectiveness as an information resource to policymakers, write or call Emily Fenichel, Editor of *Zero to Three*. She will help you select those ZERO TO THREE publications that seem most likely to match the interests of your target policymaker and refer you to other sources of information as well.

Please use the form below (and make copies as needed) to order the *Heart Start/Zero to Three Double Whammy* and the *Extra-Strength Information Package*. Because the prices for these special packages are substantially reduced, we can only offer them until April 30, 1993—the first 100 days of the new Administration and the 103rd Congress!

The Double-Whammy: Please send *Heart Start: The Emotional Foundations of School Readiness* to me, so I can add a personal letter.

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Letter to the editor

I read the August/September, 1992 issue of *Zero to Three* on drug-involved infants with great interest. I am particularly concerned with issues related to the needs of these young children for permanent, responsive care. The area of permanency planning is fraught with difficult issues. Sometimes the current system, which includes foster care, adoption, and family preservation, inadvertently adds to a child's risk of never achieving permanency. Foster care leads to permanency when and if reunification with biological parents is possible; adoption provides permanency when and if a child is legally free and adoptive parents can be found; and family preservation leads to permanency when and if the strategy can be effective. For a growing number of infants born exposed to drugs and of young children endangered by parental drug and alcohol dependency, their problems are so complex that these systems are not working. New options for making available permanent, nurturing families must be developed by the legal and child welfare system. Given this, I thought your readers might be interested in a program entitled Family Care which is being developed in Illinois to provide a new option for permanent, responsive care.

The Family Care program being developed will consist of model and community Family Care families. The model families will live in a residential neighborhood, in homes provided for them (see section on residence below); the community families will remain in their communities in their own homes. Community boards, made up of service organizations, business groups, villages, neighborhoods, adoptive parent support groups, etc., will nominate Family Care parents. Once parents have been screened, licensed, and trained (see section on training below), children will be placed with them. After children are settled into the model families, the parents, primarily in their homes, will begin training community Family Care parents. When the model parents and the community parent trainees agree the time is right, and licensing has been completed, a child or children will be placed in the home of the trainees. The community board that nominated these local parents will support and monitor the new Family Care family. The model family also will provide, on an ongoing basis, support, monitoring, and mentoring. If a child should eventually become legally free for adoption, Family Care parents will adopt the child.

The children: Families will be created for children when adoption, family reunification, and family preservation are not timely realistic options. We will concentrate on placing infants and toddlers who are at risk due to parental drug and alcohol dependency, and on groups of young siblings. Adoption agencies will be asked to find an adoptive home for each child referred to us. If the adoption agency fails to find a home for the child within a stipulated time, we will place the child in a Family Care home.

Family Care parents: Parents will be single or married, and of all races. We anticipate that most will be in their mid-thirties to early forties, will have experience in parenting, and will have a high probability of keeping a long-term

commitment to our project. With couples, one parent will hold a job in the community. We want to make it possible for an exemplary parent—for example, one now in the workforce earning \$15,000 a year as a secretary or child care worker—to stay home and raise Family Care children. To accomplish this, a Family Care parent will receive an annual salary. The model families, in addition, because of training responsibilities, will receive a house rent-free.

Residence of model families: Twelve to twenty model Family Care families will live in a residential neighborhood in single-family homes in what is currently an Air Force Base in central Illinois. This military base is scheduled to close on October 1, 1993. We are working closely with the Base Conversion Team regarding the purchase of these homes, which are in beautiful condition, have 3,000 square feet of space, and large yards. Each model family will be required to maintain the interior of their house and pay for utilities. We will be acquiring approximately 100 houses. One third of these will be used for Family Care. The remaining homes will be provided at minimal rent to foster parents and senior citizens. Our goal is to develop an intergenerational community where all members are working in some capacity to meet the needs of young children. We view this as the ultimate peace dividend.

Community boards: Community boards consist of volunteers. To date one board consists of all members of a church serving primarily low-income African-American families. A second board is made up of a group of residents of Newman, IL (population 1,000). The Newman volunteers include a beautician, two teachers, a farmer, a secretary, a school counselor, and two owners of small businesses. Several are adoptive or foster parents. A third board emerged from members of a local adoptive parent support group, Ours of East Central Illinois. Each community board will be responsible for helping to identify qualified, potential Family Care parents, community awareness (including providing information to policy makers and practitioners), ongoing monitoring of Family Care parents, and ensuring that appropriate support and networking is maintained. As the project unfolds, so will the responsibilities of the community boards.

Training: Currently model parents are beginning to receive training from a specialist in both the treatment of addiction and in parenting at-risk infants and toddlers. Once the model Family Care families are established, with children arriving over a one to two-year period, the model parents will begin to provide training to potential community Family Care parents. Training will be an ongoing and integral part of this program.

The above is an abbreviated program description. I welcome suggestions and inquiries from your readers. These can be addressed to me at 308 ISB, University of Illinois, 910 South Fifth Street, Champaign, IL 61820.

Brenda Krause Eheart
University of Illinois
at Urbana-Champaign

THE ZERO TO THREE FELLOWSHIP PROGRAM

As part of its effort to encourage a new generation of leaders in the field of infant health, mental health and development, ZERO TO THREE/National Center for Clinical Infant Programs established its Fellowship Program in 1981. The Program provides enrichment experiences for **advanced trainees** who are committed to teaching, research, the creation and evaluation of effective models of clinical service, or the development of public policies for infants and their families. The Fellowship is designed to enhance the work already being undertaken by Fellows through providing opportunities for interaction with a heterogeneous, multidisciplinary group of Fellows and Board members who represent a wide range of perspectives on infants, toddlers, and their families. The Fellowship seeks to deepen and broaden the understanding and skill of potential leaders in the field by enabling them to engage with a talented and committed group of mentors and peers. Candidates are considered from a wide variety of disciplines including child psychiatry, early childhood education, family studies, nursing, nutrition, pediatrics, psychology, occupational, physical and recreational therapy, social work, special education, and speech pathology/audiology.

THE PROGRAM

Each Fellow must be sponsored by a preceptor at his or her training site, who agrees to provide guidance in developing an individualized enrichment program to support his/her professional development as an infant specialist. This should be viewed as a one or two year commitment; the value of a second year will be weighed jointly by the sponsor, Fellow and Fellowship Committee. Each Fellow receives a \$500 cash stipend and is able to draw on an additional \$2,000 to cover the expenses of the program, which includes a seminar week for all Fellows at a training center chosen by the Fellowship Committee and participation in at least one of the invitational scientific meetings or training institutes sponsored by ZERO TO THREE each year. Seminar week, which usually takes place in the spring, provides Fellows an opportunity to share aspects of their own research or clinical work; benefit from critiques from a multidisciplinary group of current and graduate Fellows and Board members; and learn first-hand about the work of the host center.

The acceptance of a ZERO TO THREE Fellowship carries with it the obligation and agreement of both Fellow and sponsor to provide, at the end of the academic year, evaluation statements which include a general appraisal of the Fellow's professional development during the Fellowship and an evaluative summary of activities made possible by the stipend.

The relationship with ZERO TO THREE continues after the Fellowship has been completed. Graduate Fellows are invited to participate (generally at their own expense) in a variety of ZERO TO THREE activities, including training

institutes and invitational scientific meetings. They are also invited to serve on committees and task forces of ZERO TO THREE as well as write articles for the bulletin *Zero to Three*. A directory and 2 newsletters are sent annually to all Fellows to facilitate networking.

ZERO TO THREE Fellows: The First 12 Years

In each of the first 12 years, the number of Fellows selected has ranged from nine to sixteen. Collectively, the 121 ZERO TO THREE Fellows include 84 women and 37 men from more than 50 training sites.

A retrospective evaluation of the Fellowship Program from its beginning in 1981 through the class of 1987-88 was completed in 1989. Among the principal findings were:

- The program had recruited a heterogeneous group of professionals who came to the Fellowship experience from distinguished academic settings and who demonstrated recognized potential for leadership.
- Ninety five percent of the Fellows have remained in the infancy field, at least to some degree; the Fellowship Program was instrumental, and in many instances decisive, in consolidating their identity as infancy specialists and in reinforcing their commitment to remain in the field.
- The Fellowship appeared to be particularly effective in helping to overcome the sense of career isolation.
- Both Fellows and sponsors consistently cited substantial or decisive impact on career development, including access to a leadership network of Board members and other Fellows, and impacts on self-image as a future leader, functioning as a cross-disciplinary thinker, and development as an infant researcher.

Invitation to Sponsors

Fellows are selected from training centers capable of providing a two-year program of study leading to competence in clinical infant research and service. Applicants are required to be engaged in an advanced training program at least half time and for at least one year. ZERO TO THREE is interested in recruiting qualified Fellows from a diversity of backgrounds, including those who represent racial and ethnic minority groups as well as individuals with disabilities.

Requirements

Fellows must be mentored by a sponsor and show promise of becoming an exceptional professional in one of the wide range of disciplines affecting the health and development of infants and their families. Applicants should demonstrate a potential for leadership in clinical service, teaching, research, or public policy, and show evidence of scholarship and a commitment to the infancy field. In general,

preference will be given to those whose interest in infancy has already been demonstrated. Second Year Fellows will be given preference over new applicants.

Complete applications, including supporting letters, should be received at **ZERO TO THREE** by March 19, 1993. Fellowships will be awarded in April and notices mailed by May 15. The Fellowship Program year begins in September.

Questions regarding eligibility or any other aspect of the Fellowship Program should be directed to Linda Eggbeer, Fellowship Program Coordinator.

Publications:

The Zero to Three Child Care Anthology, 1984-1992 (1992) - Sally Provence, Jerree Pawl, and Emily Fenichel, Editors (ZERO TO THREE/National Center for Clinical Infant Programs, P.O. Box 96529, Washington, D.C. 20090-6529) \$14.95, plus \$4.00. shipping and handling.

This collection of 19 articles on infant/toddler child care that appeared in *Zero to Three* from 1984-1992 addresses five issues: 1) relationships in infant/toddler child care; 2) the application of principles to practice in specific settings; 3) child care for infants and toddlers with special needs; 4) financial, consultative, and other external supports for child care programs and providers; and 5) research on infant/toddler child care. Contributors include, among others, Jerree Pawl, Sally Provence, Magda Gerber, Nancy Balaban, Roseanne Clark, Mary Beth Bruder, Penny Deiner, Sandy Sachs, Donna Wittmer, Sandra Petersen, Peggy Daly Pizzo, Louis Torelli, J. Ronald Lally, Alice Honig, Jay Belsky, Deborah Phillips, Kathleen McCartney, Sandra Scarr, and Carollee Howes.

Many articles emphasize relationships as the major factor in determining the quality of child care and describe ways in which the design of programs and the most "ordinary" daily interactions among staff, children and families can reflect this awareness.

Included in the collection are Jay Belsky's 1986 essay, "Infant Day Care: A Cause for Concern?"; four extensive responses to the essay; and the text of the National Center for Clinical Infant Programs' 1987 "infant day care summit" statement, signed by 20 child development researchers, which stated:

When parents have choices about selection and utilization of supplementary care for their infants and toddlers and have access to stable child care arrangements featuring skilled, sensitive and motivated caregivers, there is every reason to believe that both children and families can thrive.

Zero to Three Classics: 7 Articles on Infant/Toddler Development (1992) - ZERO TO THREE/National Center for Clinical Infant Programs (ZERO TO THREE, P.O. Box 96529, Washington, DC 20090-6529) \$8.95, plus \$2.50 shipping and handling.

This collection of seven articles published in *Zero to Three* from 1985-1989 includes those most requested for

use as course readings by college teachers, as well as a cumulative topical index for all articles and publications reviews published in *Zero to Three* from its first issue in September, 1980 through June, 1992. *Zero to Three Classics* includes: "Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem," by Dorian Mintzer, Heidelise Als, Edward Z. Tronick, and T. Berry Brazelton; "Infants and Toddlers in Hospitals: Addressing Developmental Risks," by Barbara Kalmanson and Judith Pekarsky; "The Immediate Impact of the birth of a Low Birth Weight Infant on the Family," by Alan R. Fleischman; "The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddler, and Caregivers," by Louis Torelli; "Helping Young Children Channel Their Aggressive Energies," by Sally Provence; and "Mediating Successful Parenting: Guidelines for Practitioners," by Serena Wieder.

Dividing the Child: Social and Legal Dilemmas of Custody (1992) - Eleanor E. Maccoby and Robert H. Mnookin (Harvard University Press, 79 Garden Street, Cambridge, MA 02138) \$ 39.95.

In their examination of how divorcing parents make arrangements for their children, Maccoby and Mnookin are interested in: 1) the division of parental responsibilities after divorce; 2) legal conflict; 3) maintenance and change in the contact between parents and among parents and children; and 4) co-parenting relationships. Their study of more than 1000 California families for three years as they made post-separation arrangements for their children took place in the context of reforms in California family law which were designed to encourage greater equity between mothers and fathers, to encourage parental cooperation on children's behalf, and to ensure children continued access to both parents to the maximum practicable degree.

Maccoby and Mnookin found that despite changes in the law to eliminate gender stereotypes, the characteristic roles of mothers and fathers remain fundamentally different after divorce, with, in fact, less gender equity after divorce as mothers continue to carry major child care responsibilities and take over more responsibility for economic support. Most divorcing families have little legal conflict over the custodial or financial terms of the divorce decree, and even families with high legal conflict usually resolved disputes through negotiation rather than adversarial proceedings. The authors found that in a substantial majority of the families in their study, fathers as well as mothers remained in regular contact with their children, including families in which the children lived with the mother. With respect to co-parental relationships, the authors found that former spouses have a great deal of difficulty doing business together with respect to their children. Although conflict seems to decline over time, avoidance is commonplace. The authors acknowledge that law can be used effectively to create enforceable support obligations and to divide property, and to protect custody and visitation rights. They are skeptical, however, about family law's power to bring about fundamental change in gender roles or affect co-parental cooperation.

The authors note that although joint custody can work when parents are able to cooperate, they are deeply concerned about harm to children resulting from joint physical

custody in cases where there is substantial parental conflict. They would not, however, change existing legal standards which give a non-custodial parent the legal right to reasonable visitation. The authors support a presumption of joint legal (not physical) custody, mandatory mediation for resolving legal conflict, and the use of support schedules. They urge professionals who work with divorcing parents to avoid exacerbating conflict, to help parents develop specific and detailed plans for their co-parental relationships, and to caution parents about the use of joint physical custody when there is a great degree of parental conflict.

The Least Detrimental Alternative: A Systematic Guide to Case Planning and Decision Making for Children in Care (1991) - Paul D. Steinhauer (University of Toronto Press, 340 Nagel Drive, Buffalo, NY 14225) \$24.95.

Contemporary foster care, argues Dr. Peter Steinhauer, is concerned chiefly with "special needs" children, who come into care with multiple physical, mental, emotional, and behavioral problems. Therefore, routine foster care, to be adequate, must really be specialized care, and foster parents need ongoing training, supervision, and support. To minimize the potentially destructive effects of poorly planned long-term foster care, Steinhauer offers seven keys to the preventive use of foster care:

- Any demand for a child's removal from the home deserves immediate crisis intervention.
- Avoid colluding with family scapegoating.
- Plan aggressively to protect continuity with children's major attachment figures by systematically assessing and predicting parenting capacity (the author offers guidelines); protecting continuity to key attachment figures; promoting multiple attachments, whenever indicated; and using active/systematic decision making at every stage.
- Actively assist the work of mourning.
- Use visits preventively—Steinhauer notes that if very young children are deprived of access to their natural parents for even a few weeks, they will react as if the parents have been permanently lost and will begin to detach from them. An "agency-induced abandonment" will encourage young children to form a substitute attachment to foster parents, from whom they may have to undergo a second separation should they be returned to biological parents who, through agency neglect, have been allowed to become psychological strangers.
- Direct casework toward the optimal functioning of the foster care system, with adequate psychiatric/psychological consultation available as back up.

The volume describes four models of enriched care that include foster parents serving as parent-therapists (rather than just parent surrogates), payment of salaries to one or both members of a foster parent couple, changes in contract and recruitment, respite care, a systemic view of the foster-care system, and a heavy reliance on foster-parent groups as a major source of support, training and supervision for foster parents, who were seen as the major therapeutic influence on the child in care, with social workers and mental

health professionals having primarily a supervisory or consultant role.

Fair Start for Children: Lessons Learned from Seven Demonstration Projects (1992) - Mary Larner, Robert Halpern, and Oscar Harleavy, editors (Yale University Press, 92A Yale Station, New Haven, CT 06520) \$27.50

This volume includes detailed accounts of the experiences and problems faced by teams of practitioners and researchers in seven diverse communities as they developed, with support from the Ford Foundation, preventive outreach programs designed to improve chances for the survival and healthy development of infants and young children in disadvantaged low-income families. The seven Child Survival/Fair Start (CS/FS) projects were scattered from New York to Florida to Texas to Minnesota, and many offered education, support, and information services (typically through home visits) to several sites in different counties or states. A gradually evolving network linked the seven independent projects. The CS/FS projects were designed to test variations of a common preventive strategy:

1. They focused on families in poor communities rather than individual families at special risk.
2. They provided low-intensity services (biweekly or monthly home visits or group meetings) over a long period of time (from pregnancy until one or two years after the child's birth).
3. They attempted to integrate information and assistance related to health and developmental concerns in a single, generalist approach.
4. They employed community (paraprofessional) workers as primary staff who worked with families to link them to professional services.

The editors suggest that modest expectations are appropriate for such programs, which should be viewed as part of a larger array of responses to families' needs. They derive key principles, based on the CS/FS experience, to guide the development of future programs:

- The heart and soul of services are caring relationships, not information, instruction, or procedures.
- Maintaining a balance in the attention given to the needs of parent and baby is extremely difficult, but essential to maintaining a program's ecological breadth and power.
- Community-based programs are not equipped to address many family needs, and thus must establish links to mainstream service systems.
- Community workers can play a viable role if they have clear expectations, role boundaries, and ongoing training and supervision in a carefully managed program.
- Programs inevitably evolve and are shaped by the character and life of the community in which they are embedded; consequently successful problem-solving strategies must be altered to fit the relatively specific local causes of the problems being addressed.

Children in Poverty: Child Development and Public Policy (1991) - Aletha C. Huston, editor (Cambridge University Press, 40 West 20th Street, New York, NY 10011) \$44.50.

Based on a working conference on children and poverty held at the University of Kansas in the summer of 1988, this volume includes contributions from experts in economics, sociology, public health, psychology, child development, and education. These are, among others, Aletha Huston, Lorraine Klerman, Vonnie McLoyd, Deborah Phillips, Craig Ramey, Lisbeth Bamberger Schorr, and Leon Wilson. The book addresses questions about: 1) the extent and etiology of the 20-year deterioration in economic status of families with children; 2) the effects and mechanisms of transitory and persistent poverty on children's physical, cognitive, social, and emotional development; and the role that public policy and policy research can play in preventing or alleviating the damaging effects of poverty on children.

In a chapter called "The strain of living poor: Parenting, social support, and child mental health," Vonnie McLoyd and Leon Wilson present findings to suggest that when a mother is in poor mental health—a state that increases as her economic situation worsens—she is less satisfied with the parenting role and less likely to behave positively and supportively toward her child. This behavior, in turn, appears to contribute to feelings of depression and anxiety in the child. This model, the authors note, differs from theories that postulate a stable, intergenerationally transmitted "culture of poverty" that results in negative child outcomes. McLoyd and Wilson note that any movement from welfare to work, whatever its impetus, should be viewed as a family transition rather than an individual transition made by a mother:

If the physical and psychological demands, role strain, and other pressures generated by the transition are not counterbalanced by psychological and material rewards such as a meaningful increase in the family's standard of living or the mother's self-esteem, feelings of efficacy or control over her life, and expectancies for the future, the transition may actually have deleterious effects on the mother's psychological functioning. This outcome may adversely affect the quality of child rearing and family life and, in turn, children's mental health. It is also worth noting that a mother's mental health is likely to be influenced by whether her children cope well or poorly with new experiences precipitated by the transition (e.g., daycare).

Overcoming the Odds: High Risk Children from Birth to Adulthood (1992) - Emmy E. Werner and Ruth S. Smith (Cornell University Press, 124 Roberts Place, Ithaca, New York 14850) \$42.50 cloth, \$15.95 paper.

This is the fourth volume to document the Kauai Longitudinal Study, which began in 1955 to monitor the impact of a variety of biological and psychosocial risk factors, stressful life events and protective factors on 505 individuals whose lives have been followed from the prenatal period

to adulthood. The present volume has two main objectives: 1) to trace the long-term effects of childhood adversity on the adult lives of men and women who were exposed to poverty, parental discord or psychopathology, and perinatal stress; and 2) to examine the long-term effects of protective factors and processes that led most to a successful adaptation in adulthood. In this volume, Werner and Smith also refer to the findings of other prospective longitudinal studies by Elder, Vaillant, Mednick, Anthony, Rutter, Wallerstein, Furstenberg, and their colleagues.

Among other findings, Werner and Smith note that of the 500 children in their study, one out of every six children in the cohort who survived infancy had physical or intellectual handicaps of perinatal or neonatal origin which were diagnosed between birth and age 2 and which required long-term specialized medical, educational, or custodial care. However, the impact of reproductive stress diminished with time, and the developmental outcome of virtually every biological risk condition was dependent on the quality of the rearing environment. Prenatal and perinatal complications were consistently related to impairment of physical and psychological development in childhood and adolescence only when they were combined with chronic poverty, parental psychopathology, or persistently poor rearing conditions, unless there was serious damage to the central nervous system.

Discussing the implications of their findings for social action, Werner and Smith agree with Michael Rutter that we need to focus on the protective processes that bring about changes in life trajectories from risk to adaptation: 1) those that reduce the risk impact; 2) those that reduce the likelihood of negative chain reactions; 3) those that promote self-esteem and self-efficacy; and 4) those that open up opportunities. They stress the importance of supportive relationships—the "resilient" children in their study all had at least one person in their lives who accepted them unconditionally, regardless of temperamental idiosyncracies, physical attractiveness, or intelligence.

The authors suggest that in setting priorities for the investment of public resources, intervention programs need to focus on children and youths who appear most vulnerable because they lack some of the essential personal resources or social bonds that buffer chronic adversity or stress. However, assessment and diagnosis need to focus not only on risk factors in the lives of these children but also on protective factors, such as competencies and sources of informal support that can be used to enlarge a child's repertoire of problem-solving skills and self-esteem and self-efficacy. They note that informal and personal ties, such as extended family members, child care providers, teachers, and youth workers, are preferred by most children and families to impersonal contacts with formal bureaucracies.

Call for papers:

The Future of Children announces the publication of an annual multi-topic journal issue, beginning in Fall, 1993. Policymakers, clinicians, practitioners, and researchers are invited to submit their commentary, research, and analysis for publication in these multi-topic issues. Manuscripts must be received by February 1, 1993 to be considered for the Fall, 1993 issue. Manuscripts submitted after this date will be considered for publication in the Fall, 1994, or a subsequent multi-topic issue.

Papers should be submitted to the Editor, Richard E. Behrman, M.D., The David and Lucile Packard Foundation, Center for the Future of Children, 300 Second Street, Suite 102, Los Altos, California 94022.

Conference call:

March, 1993

March 10-13: *Greenville Technical College and the National Coalition for Campus Child Care* will host a conference on Hilton Head Island, South Carolina entitled "Professional Leadership—Turning the Tide for Quality Campus Child Care." Ellen Galinsky, Thelma Harms, and Pamela Boulton will deliver keynote addresses. Write to Karen Holbrook, Continuing Education, Greenville Technical College, P.O. Box 5626, Greenville, SC 29606-5616.

March 11-13: *The Children's Defense Fund's Annual National Conference*, entitled "Leave No Child Behind: Mobilizing Families and Communities for America's Children," will be held in Washington, D.C. The conference will feature 45 workshops and a special preconference advocacy training seminar on March 10. Contact the CDF Conference Hotline at (202) 662-3684 or Ann Delory, tel: (202) 628-8787.

March 25-27: The *Southern Association on Children Under Six* will hold its 44th annual conference in Biloxi, Mississippi. Joycelyn Elders, M.D., director of the Arkansas Department of Health, will be among the featured speakers. For information, write to SACUS in Biloxi, P.O. Box 5403, Little Rock, AR 72215-5403.

March 30-April 4: The *National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)* will hold its 14th Annual Nursing Conference on Pediatric Primary Care in Anaheim, California. Mary Fenton will deliver the keynote address. Contact NAPNAP Conference Office, North Woodbury Road, Box 56, Pitman, NJ 08071.

March 31-April 2: The *Child Care Action Campaign (CCAC)* and the *Council of Chief State School Officers* will sponsor a conference in New York City entitled "Child Care and Education: The Critical Connection." For information, write or call CCAC, 330 Seventh Avenue, 17th Floor, New York, NY 10001, tel: (212) 239-0138.

April, 1993

April 17: The *Center for Parent Education* of the University of North Texas will sponsor a conference in Denton, Texas on parent education. Contact Dr. Arminta Jacobson, P.O. Box 13857, UNT, Denton, TX 76203-3857, tel: (817) 565-2432.

April 18-20: The *National Center for Family Literacy* will hold its second national conference in Louisville, Kentucky

with the theme, "Fostering Success from Generation to Generation: Literacy - Family - Community." Contact Ellen Shaikun, National Center for Family Literacy, 401 South 4th Avenue, Suite 610, Louisville, Kentucky 40202-3449, tel: (502) 584-1133.

April 22-24: The *University of British Columbia* will offer a conference entitled "Pediatric AIDS: Women, Children, Youth, and HIV" in Vancouver, British Columbia, Canada. For information, contact 1993 Pediatric AIDS Conference, Continuing Education in the Health Sciences, Room 105-2194 Health Sciences Mall, The University of British Columbia, Vancouver, BC, Canada V6T 1Z3, tel: (604) 822 2626.

April 28-30: The *California Center for Childhood Injury Prevention* will hold its seventh annual conference in San Diego, California, to focus on state and national injury control priorities, research, and lessons learned from injury prevention program models. Contact Debbie Loomis, California Center for Childhood Injury Prevention, Graduate School of Public Health/MCH Division, San Diego State University, 6505 Alvarado Road, Suite 205, San Diego, CA 92120, tel: (619) 594-3691.

June, 1993

June 14-18: The *Seventeenth Annual Quality Infant/Toddler Caregiving National Workshop* will be presented by Alice S. Honig in Syracuse, New York. For information, contact Alyce Thompson, Syracuse University, Quality Infant/Toddler Caregiving Workshop, 201 Slocum Hall, Syracuse, NY 13244-1250, tel: (315) 433-2757.

July, 1993

July 19-23: The *International Society for the Study of Behavioural Development* will hold its twelfth biennial meeting in Recife, Brazil. Margret Baltes, Steve Ceci, Emilia Ferreira, Nathan Fox, Chen-Chin Hsu, Lars-Goran Nilsson, Tetsuro Matsuzawa, Maria Clotilde Rossetti-Ferreira, and Gerard Vergraud will give invited addresses. For information contact Lair Buarque - ISSBD93, CPCH Universidade Federal de Pernambuco, Cidade Universitaria, 50.739 - Recife - PE - Brazil, fax: 55-81-271-1843.

Summer Fellowship Program in Child and Family Policy

The Chapin Hall Center for Children and the Harris Graduate School of Public Policy Studies at the University of Chicago are pleased to announce the second year of the summer program for graduate students in child and family fields entitled: "Fellowships in Child Welfare and Family Policy." In cooperation with the Society for Research on Adolescence (SRA) and the Society for Research in Child Development (SRCD), the program will offer full-time summer placements for 2-3 months in a variety of policy settings in Chicago, combined with weekly seminars at the university. **The deadline for applications is March 1, 1993.** Fellowships will begin in June, 1993 and end in August. Fellows receive a monthly stipend; they will be responsible for travel to Chicago and for housing. To apply, send a 3-page statement describing your interests in policy and research, and how you hope the fellowship would further your career; a current resume; and 2 letters of recommendation. For further information, contact P. Lindsay Chase-Lansdale or Joan Wynn, Chapin Hall Center for Children, University of Chicago, 1155 E. 60th Street, Chicago, IL 60637 (312) 753-7922.

If you found this issue of **Zero to Three** on infants, toddlers, families and the justice system informative and helpful, you may wish to order back issues of **Zero to Three** on related topics:

- * 47 _____ Adoption (June, 1990)
- * 46 _____ Early intervention policy and practice (February, 1992)
- * 81 _____ Drug-exposed infants and their families (August/September, 1992)

Back issues are available for \$6 each.

* 66 _____ **Can They Hope To Feel Safe Again? The Impact of Community Violence on Infants, Toddlers, Their Parents, and Practitioners** (1992) is the edited transcript of three presentations by front-line practitioners, researchers, and community activists, who describe the experience of working with very young children and families who live in violent communities. **Can They Hope to Feel Safe Again?** is available for \$5.

Quantity discounts are offered.

To order the publications listed above, or to request a twelve-year cumulative index to **Zero to Three**, call toll free 1-800-544-0155.



Zero to Three Insert



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